INTERDISCIPLINARY/INTERPROFESSIONAL TEAMWORK: SOCIO-CULTURAL AND PSYCHOLOGICAL DETERMINANTS OF TEAM CONFLICT

By

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This dissertation is a qualitative ethnographic case study of the collaborative difficulties between social science and medical personnel in an interdisciplinary/interprofessional health care team, the Children's Health Program (CHP) team of South City. The study examines these two groups as distinct subcultures, one consisting of medically oriented individuals providing medical or psychological therapy and the other formed by social scientists acting as researchers. Within this structure, the clinical group wielded considerably more influence than the researchers, and the physician dominated the CHP team. The mirror image of clinical dominance within the team was the secondary or subsidiary status of social science.

Dissension within the CHP team manifested itself in two major forms of role conflict. The first occurred when medical personnel asked the social scientists to assist with the clinical goals of program funding and psychological care. The second resulted when medical personnel seemed to deemphasize research, the area which the social scientists believed to be their essential contribution. As the dominant group, the clinical staff expected the social scientists to conform to medical expectations.

Personality, gender, ethnicity and social class are also examined as elements affecting team collaboration. As factors operating within the context of professional subcultures and medical dominance, they are seen as important but secondary influences on team operations.

Research on interdisciplinary/interprofessional health care teams has indicated the commonality of dissension on such teams. This study confirms that diagnosis but, unlike previous studies, offers a more comprehensive and thorough explanation by utilizing the concept of professional subcultures. The dissertation concludes with suggestions for the recognition and resolution of team conflict.

CHAPTER I
INTRODUCTION

In recent decades the traditional doctor-nurse team as the basic model for health care has given way to new types of health care teams. Spurred by spiralling medical costs and concern over the quality of health care and by the desire to improve service delivery, medical personnel began to create teams composed of a variety of individuals drawn from different professions or disciplines. Largely in response to a demand for increased accountability, there has also been a trend to include researchers as members of practicing clinical teams. One result has been the interdisciplinary/interprofessional team, an arrangement intended to enhance the quality of medical care by pulling together individuals with specialized knowledge of "medical" problems.

The subject of this study, the Children's Health Program (CHP) team of South City,[1] is an example of an interdisciplinary/interprofessional team which grew out of this movement toward more complex team arrangements. As a relatively new phenomenon, the interdisciplinary/interprofessional team has not been the subject of significant social science research. Despite the strong contemporary interest

in such health care teams, their effectiveness as a method of health care delivery has yet to be evaluated. The emphasis in teamwork literature has been on the creation of teams, rather than on careful evaluation of their actual operation. With a few notable exceptions (Berlin 1970; Rae-Grant and Marcuse 1968), individuals associated with teams have tended to assume that teams are a superior means of delivering health care. This has not been confirmed.

Despite the lack of adequate research, teamwork has been promoted at times with an almost evangelistic fervor, leading the sociologist Saad Nagi to suggest that teamwork has become more a matter of "morals" than of strategy (1975:75). Practitioners expect teams to yield improved care by offering increased coordination and integration of services. They have increasingly found themselves in difficult positions, often faced with complex disease entities which seem to defy cure. Cardiovascular heart disease and alcoholism are two examples of fields in which the etiology and means of treatment are often in dispute. Due to a vastly increased network of health and social care, moreover, there is a bewildering array of professionals prepared to treat one aspect or another of these problems.[2] In response to a situation of enormous complexity, the primary problem quickly has become one of coordination, and teams have been hailed as "the" answer.

Promoting teams as the solution to most health care problems seems premature. Available research suggests that medical teams are not a panacea for today's health care needs. The literature on teamwork, for example, is nearly unanimous in pointing out two serious problems with health care teams: team conflict and medical dominance. Although one or both of these is mentioned in almost every work on teams, it is usually in a somewhat cursory way, and without any connection necessarily being made between the two.

The widespread reporting of conflict between professionals within teams indicates strongly that team conflict is an issue of some concern. If, as a recent study has suggested, collegiality within teams has a positive effect on treatment outcome (Feiger and Schmitt 1979), one might well wonder if the omnipresence of team dissension does not have a negative impact upon the quality of health care offered by teams. Although this association was actually first noted in the 1950s by researchers analyzing staffing patterns in mental hospitals (Henry 1960; Stanton and Schwartz 1954), it is surfacing again as a nagging worry for thoughtful team analysts (see, for example, Furnham, Pendleton and Manicom 1981). Richard Beckhard, for example, has defined the "effective" team as one in which more time is devoted to delivering patient care than to fighting over organizational issues (1972:292).

The attention accorded medical dominance in team literature indicates that it is an issue of prime importance. The term medical dominance refers to the tendency for health care teams to favor medical concerns and to allow physicians to automatically assume leadership roles on teams. Ironically, the ideological support for teams is based on the assumption that they might help to solve certain medical problems (for example, the mounting cost and increasing inaccessibility of medical care) by utilizing "teams" in which all members are equal participants. The "problem" of medical dominance, therefore, might be resolved through a real equality of other participating professionals and disciplines. It is worthwhile, then, to examine teams to determine if there is equal participation among team members and if the team is moving successfully toward the goal of improved health care.

The problems of team conflict and medical dominance suggest the importance of examining more closely the value or operational effectiveness of health care teams. It is the purpose of this study to do so by providing a detailed evaluation of one particular team, in this case an interdisciplinary/interprofessional health care team. Since research on health care teams has been limited or inadequate, I drew a blank when searching team literature for approaches that might be of use in studying the Children's Health

Program (CHP) team operations. Choice of methodology for my examination of collaborative difficulties within teams, therefore, became an important problem.

I turned to the history of applied research in quest of possible approaches to the study of team collaboration. Anthropology's focus on cultures and its resulting concern with subcultures and subcultural differences offered the best analytical tool for examining the fit of individual team members within the culture of the CHP team. A subcultural analysis of the process of teamwork functioning, however, has not been undertaken previously. By adopting such a methodological approach, this study provides not only a unique approach to health care team analysis but also an evaluation of the problems which have plagued the operation of health care teams.

The purpose of this chapter is to assess the value of previous teamwork literature as a means of developing a detailed explanation of the weaknesses and strengths of research to date. From this review it will become evident that a more systematic and in-depth approach to health care team analysis is essential if the key problems of teamwork are to be addressed effectively. This chapter also outlines the basis for my selection of an alternative subcultural approach. Combining the strengths of previous literature with my own anthropological orientation, I adopted a

methodology which seemed to analyze the CHP's interdisciplinary/interprofessional health care team.

Chapter II sets forth the circumstances and history of the CHP team. It is designed to orient the reader to the fieldwork setting and to indicate the background of the team both before and immediately after my arrival in South City. Chapter III provides an in-depth explanation of the choice of a qualitative methodology, rather than a quantitative one, and carefully outlines the actual research process which I followed.

The purpose of Chapter IV is to discuss the conceptualization of two subcultures within the CHP and to document the presence of medical dominance. One subculture was formed by members of the social science disciplines and the other by medical and related clinical professionals. Chapter V explains the necessary and concomitant secondary status of social science within this arrangement and reveals the resulting discomfort and low morale of the social scientists. The root of the differences between the two subcultures is the focus of Chapter VI. It focuses on the differences in goals and values in an effort to explain the two critical forms of role conflict which occurred within the CHP team.

Chapter VII investigates the contribution of personality, gender, ethnicity and social class to team conflict.

They are treated as independent variables, operating in the context of subcultural conflict and medical dominance. Chapter VIII concludes the study by defining the fundamental issues which emerged between the social science disciplines and medical professionals as role conflict and role conflict resolution. It also offers suggestions for overcoming problems of dissension within teams and for establishing future research directions.

Review of the Literature on Teamwork

The health care team is a subject which has received considerable attention from social scientists in recent decades. Most of the literature, however, has tended to present the common problem of team conflict without providing adequate explanation of such conflict. Because of this insufficient attention to the dynamics of teamwork, there is no precedent in the literature for an in-depth analysis of any particular health care team. It is necessary, therefore, to review both teamwork literature and the history of applied anthropology for helpful clues and analytical assistance.

The review of the literature examines both general teamwork and the more specialized interdisciplinary/interprofessional teams being studied here. Its purpose is to assess the various approaches that have been utilized by researchers in an effort to determine the methodology most

appropriate to studying interdisciplinary/interprofessional teams. In general, previous research has tended to be descriptive, rather than analytical, thereby giving a superficial quality to many of the conclusions. The shortcomings of previous studies, combined with my anthropological orientation, led me to adopt the anthropological construct of subcultural conflict as a means for analyzing team conflict in the CHP's interdisciplinary/interprofessional team.

Definition of Teamwork

The use of interdisciplinary teams to provide health care has grown to almost faddish proportions. One hears the term "teamwork" brandished everywhere: there are health teams, interdisciplinary teams, comprehensive health care teams, medical teams and so on. This rapid increase in the number and types of team formations has occurred within the last three decades (Nagi 1975).

Richard Beckhard defines a team as "a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members" (1972:292). Other definitions are more specific. A team is described as "face-to-face interaction" (Nagi 1975:77) between two or more persons (Rubin, Plovnick and Fry 174:4) in which a "number of associates all subordinate personal prominence to the efficiency of the whole" (Webster, as quoted in Rae-Grant and Marcuse 1968:4). Definitions of the

words "health team" are almost as multitudinous as the teams themselves. As George Szasz points out, the use of these words is indiscriminate and may refer to (1) any of those professionals who belong to the health industry, (2) select groups of professionals who are working together, or (3) members of a health care delivery team who employ the "health team method of health care" (1969:454). In this study the word team will be used only to refer to a situation in which more than two collaborators from more than two professions or disciplines meet in face-to-face interaction in pursuit of a specific human service or health care goal.

The traditional team within the profession of medicine has been that of doctor and nurse. A dominant-subordinate relationship has characterized this arrangement, with the nurse usually cast in the submissive role (Peeples and Francis 1968; Wise, Rubin and Beckhard 1974). The highly structured nature of such relationships, particularly within surgical teams, has been noted by both Robert Wilson (1966) and Ruth Coser (1958). This customary assortment of professions has sometimes been expanded to include social workers (Burn 1971; Burr 1975; Tanner and Carmichael 1970), professionals who have also played roles subordinate to that of the physician.

In contrast, recent developments have changed the very nature of health teams. Positions have been developed for

new medical personnel, especially nurse practitioners and physician's assistants. Areas of social science such as medical anthropology and medical sociology have been drawn into, or have made room for themselves in, the field of health care. Health teams today may be composed of various combinations of traditional and modern medical and social science personnel, and at times even include patients. Of particular interest is the inclusion of social scientists such as anthropologists (Foster 1974; Hasan 1975; Leighton 1972; Richards 1970) and sociologists (Olesen 1974; Rosengren 1967) as members of medical teams. There has been a growing concern with the possibility of contributions from these and other regions of specialization--areas such as the ministry (Duncombe and Spilman 1971) and geography (Hunter 1973). A strong, popular interest has developed in the wake of these team efforts. Proof of this may be found in the ever-increasing number of semi-popular articles published in health journals (Frank and Frank 1975; Margolin 1969; Mason and Parascandola 1972).

The new health care team is thus different in many ways from the familiar hospital surgical team. Richard Beckhard (1972) has pointed out some distinctions between these two teams. Comprehensive health care teams, for example, are distinguished by discussion and problem solving as a method of communication, and they will usually find the process of

decision making to be unclear, their roles to be ambiguous and their purpose (the delivery of comprehensive health care) to be general. Surgical teams, on the other hand, are characterized by one-way commands as a means of communication and will usually find the procedures of decision making to be hierarchical, their goals to be clear and their purpose to be specific ("operate" and "close up").

Teamwork has been justified in many ways. Some frequently mentioned explanations are the need for manpower, the increasing complexity of health problems and the necessity for reorganizing the health system for more efficient delivery of health care. In Beckhard's estimation, the issue of manpower is important. He declares teamwork to be a necessity in needy communities where access to trained professionals is limited (1972). In such cases team arrangements can allow a doctor, for example, to see only those patients who are most seriously ill. The problem here may not be a shortage of physicians but the difficulty of coordinating the roles of many health professionals (Nagi 1975).

The complex nature of health care concerns has been cited by many researchers as justification for teamwork. Health issues have social, cultural, behavioral and biological causes (Talbot 1968), and it is felt that the intricate nature of these and other present-day social problems makes

the achievement of understanding unlikely if the insights of other disciplines are not considered (Roose 1969). As John Hunter remarks: "Like most complex phenomena involving man, health problems defy compartmentalized thinking and segmented solutions" (1973:2). Irvin Rubin, Mark Plovnick and Ron Fry argue that teams are a requirement if the goal of comprehensive health care is to be achieved (1974).

History of Teamwork Literature

Interdisciplinary research teams. The history of contemporary teams, emphasizing cooperation and equality between members, stretches back over four decades. A number of articles on the formation of interdisciplinary research teams were published immediately following World War II, stimulated by the interdisciplinary work occurring during the war. As a general rule, these articles examined the negative impact of personality upon team research and the difficulty of understanding the theoretical constructions and methodological approaches of other disciplines (Blackwell 1955; Bronfenbrenner and Devereaux 1952; Caudill and Roberts 1951; Eaton 1951; Frank 1961; Redlich and Brody 1955; Reusch 1956; Simmons and Davis 1957; Wohl 1955). A few authors address the particular situation of social scientists conducting research in clinical settings (Goss and Reader 1956; Mitchell and Mudd 1957; Young 1955), presenting an overview; yet, others discuss trends within the general

field of interdisciplinary research (Luszki 1957; Sherif and Sherif 1969).

Since the 1940s, social psychologists have been interested in studying group behavior (Zander 1979). The field of "group studies" developed just prior to World War II and grew rapidly after the war. It was characteristically infused with the sense of hopeful enthusiasm concerning engineered social change that also typified other applied social disciplines during that era. In 1947 the National Training Laboratories were established as a means of studying group behavior through T-groups, but as time passed the Laboratories actually appeared to have the effect of decreasing regard for groups. They were moved to the University of Los Angeles, where they came under the influence of students of personality theory (rather than social psychologists), and T-groups developed into a form of sensitivity training concerned with increased individual self-awareness.

As the personal growth industry became big business during the 1960s and 1970s, there was a corresponding decrease of interest in the study of small groups (Goodstein and Dovico 1979). The resulting "applied group movement" which is alive and well today is not the same as the study of groups (Back 1979). Group experience of the former type provides a source of comfort to individuals seeking a quick

and inexpensive means of addressing their perception of personal and social malaise rather than, as was intended in the original T-groups, a clearer understanding of the process of group dynamics.

Interprofessional clinical teams. It is true that both social scientists, interested in organizing interdisciplinary research, and social psychologists, actively researching small groups, became interested in groups as a means of effecting organizational goals during the post-World War II years. To date, however, there seems to have been virtually no cross-fertilization between these two areas of inquiry. A similar issue may be raised with reference to yet another arena developed through the efforts of mental and physical health professionals: clinical health and human service interprofessional teams.

These nontraditional clinical teams began to appear in the late 1950s. They were radically different in organization and intent from the traditional doctor-nurse medical teams. That these teams were numerous is demonstrated in the review of the literature produced by Rosalie Kane (1975) and in Monique Tichy's annotated bibliography (1974).

Literature on interprofessional clinical teams falls into four main categories. The first tends toward popular "wave of the future" exhortations: "Try it, you'll like it" (Burn 1971; Burr 1975; Margolin 1969). The second

introduces descriptions of teamwork problems, usually in reference to one particular team (Fry and Miller 1974; Lamberts and Riphagen 1975; Sims and Bauman 1975).

The third category of interprofessional team literature is made up of brief analyses, usually by sociologists, which assess the impact of social structure upon role behavior (Nagi 1975; New 1968). Much of this literature focuses on roles, thereby highlighting the role confusion often experienced in interprofessional teams. There is a certain amount of overlap and duplication between the disciplines sometimes included in one team, as in the cases of psychiatrists and psychologists or of physicians and physician's assistants. Conflict over professional domain is the not uncommon result (Nagi 1975). Team members may not understand the possibilities offered by another individual's discipline, and they may have differing or erroneous impressions of each others' expertise, or they may feel threatened by other team members who share their own area of proficiency.

Decisions about professional domain and assigned responsibility are difficult to make within teams. Some analysts feel that job descriptions may prove counter-productive if they limit the potential for individual growth and development offered by flexible team organization. Adaptability of roles is often cited as a strong point of teams

(Beckhard 1972; New 1968; Rubin and Beckhard 1972). These and similar attitudes can lead, of course, to further role conflict if team members are unable to agree upon a division of labor.

General tracts, usually written by or for social workers who will be working in teams, are the fourth type of literature on interprofessional clinical teams (Brieland, Briggs and Leuenberger 1973; Brill 1976; Horwitz 1970; Lambertsen 1969; Rubin, Fry and Plovnick 1978). The best works in this category are sensitive to some of the factors which might be influencing team cooperation (Golin and Ducanis 1981); the worst merely provide a laundry list of items. None of them explains the process of teamwork and none of them offers a coherent theory of teamwork.

Despite significant differences in quality, this literature on interprofessional teamwork does concur in raising the issue of conflict in contemporary health care teams. Almost every article mentions the difficulty of collaboration. To address these problems, management specialists began to work with health care teams in the 1960s. It was at this time that Irwin Rubin, an expert in organizational development and team building in industry associated with M.I.T.'s Sloan School of Management, began consultant work with the Martin Luther King, Jr., Health Center in Bronx, New York. Rubin applied behavioral science and management

concepts to the problem of increasing team effectiveness and came up with the concept of team development, a process in which teams are helped to process the internal dynamics of their own group's functioning. His approach concentrates on internal group behavior, without regard for the larger socio-cultural context within which the team operates. Rubin and his associates have published a number of reports on their work (Beckhard 1972; Beckhard 1974; Rubin and Beckhard 1972; Rubin, Fry and Plovnick 1978; Rubin, Plovnick and Fry 1974; Wise et al. 1974; Wise, Rubin and Beckhard 1974).

Interprofessional team literature strongly emphasizes the notion of joint clinical experience as a prescription for decreasing "barriers" to teamwork. Those who do not advocate the use of team development (Kindig 1975) suggest the employment of T-groups (Odhner 1970; Semrad and Arsenian 1951). Both processes are essentially the same, as both seek to facilitate learning about group dynamics by team members. A recent study, however, suggests that the process of team development does not result in improved team performance, but in a more positive perception by team members regarding their situation (Woodman and Sherwood 1980).

Others recommend pre-dating group experience for teams by organizing interprofessional programs of training. The problem in bringing this about seems to be that medical students do not respond well to presentations on behavioral

science theory, feeling it to be "irrelevant and, at best, trivial" (Volpe 1975:493). When courses for students are changed to decrease medical bias, students are reportedly unhappy (Howard and Byl 1971) and resent having their learning "diluted" (Szasz 1969:466). All such educational efforts, of course, are based on the assumption that a change in educational format will lead to a change in student attitude. Bonito and Levin point out that such an assumption may be unwarranted and they recommend investigating such additional factors as socialization, self-selection and generational effects (1975).

Interdisciplinary/interprofessional teams. Another type of team came into being in the late 1960s: the interdisciplinary/interprofessional team. In such teams social scientists were charged with the responsibility of researching the program in which clinical professionals were working (Bennett and Lumsdaine 1975). Development of "Great Society" social and health programs during those years stimulated a corresponding demand for evaluation, since both government and the public wanted assurances that tax dollars were being spent in the most effective manner. As social programs multiplied during the 1960s, legislation also changed to mandate accountability. The field of evaluation research expanded to meet that demand.

Most of the literature concerning interprofessional relationships within interdisciplinary/interprofessional teams is buried in discussions of evaluation methodology. Although program evaluators are aware of the determining influence of "organizationally structured strains" and of the anxiety engendered by evaluation (Rodman and Kolodny 1971; Skipper, Diers and Leonard 1967; Weiss 1977), they have no integrated explanatory model on which to base their discussion of conflict in teamwork.

Additional information on interdisciplinary/interprofessional teams may be found in writings of anthropologists who discuss the "adjustment" required of academicians moving into clinical settings. Their ruminations, however, produce little more than general reports on the discomfort engendered by such moves (Kennedy 1979; Leighton 1972; Richards 1970; Schensul 1979; Weaver 1968).

In summary, the review of the literature indicates that various types of teams have been in operation since the 1940s, and that some attention has been given to evaluating their contribution to American health care. From the interdisciplinary research teams of the 1940s and 1950s to the more modern interprofessional clinical health care teams and interdisciplinary/interprofessional research-practitioner teams, the health care team has been applauded as a useful device for delivering health care. Regardless of the period

or type of team being examined, the literature usually tends to be descriptive and prescriptive rather than analytical. Its most glaring fault is its narrow scope, a weakness which results from the tendency of social researchers to ignore the work of their counterparts in other disciplines. The inadequacy of previous health care team literature was the basis, in part, for my decision to adopt a new methodological approach to the study of the CHP team. Since the ground broken by earlier social scientists did not bear fruit, I determined to add important new elements to improve the yield. The anthropological concept of subcultures, building upon the best from previous team research, seemed the most appropriate road to follow.

Applied Anthropological Research

To summarize, anthropology has always distinguished itself from other disciplines by its focus on culture. Between the 1920s and the 1940s the earlier "museum-like" approach to its subject was modified by the addition of three new elements: the method of participant observation, increasing opportunities for non-academic work, and decreasing availability of isolated cultures traditionally favored by anthropologists. Applied anthropology was born of these changes, and its influence was felt in a flurry of activity during and after World War II. The relative lull

of the late 1950s and 1960s was ended by renewed activity in the 1970s and 1980s, particularly as a result of a decrease in academic employment.

Since World War II, applied anthropology has been subjected to the influence of a fifth element: quantification. In the form of evaluation research, quantification has traditionally been the method of choice in agency and institutionally based research.[3] Because anthropologists are again working in these settings, they have had to adopt, or adapt to, quantitative methodology.[4]

Exposure to quantitative research, and to situations in which quantitative research is valued, if not demanded, has had a major impact on the present-day field of applied anthropology. Michael Angrosino (1976), for example, speaks of the "new" applied anthropology in reference to the problem-oriented procedures required in current applied work. He notes that anthropologists have traditionally been unwilling to "dirty" their hands with administrative or bureaucratic responsibilities. There is, however, a limited demand for the traditional qualitative ethnographic contributions of anthropologists (Agar 1980). Qualitative research is usually too time consuming to be completed as a part of short-term contract work. What is needed within the new multidisciplinary agency framework is "quick and dirty" survey work. This is not traditional anthropological

research and some anthropologists have responded by teaching themselves new research skills. Programs of applied anthropological training have reacted by incorporating training in quantitative methodology.[5]

This particular study focuses on the kind of applied setting in which anthropologists began to work in the 1970s: an interdisciplinary/interprofessional health care team which employs anthropologists and other individuals from diverse disciplines and professions. As a qualitative study, moreover, it fits squarely within the tradition of applied medical anthropology research. As an evaluation of team functioning, it focuses on the organizational structure of medical care and considers the efficiency of different forms of health care organization. My own work as an applied anthropologist-health care team member is a reflection of the larger change occurring within the discipline and within United States health care as more anthropologists become heavily involved in planning, delivering and evaluating health care programs.

The value of applied anthropology is that it offers both the concept of culture and a qualitative methodology with which to explore previously unexamined settings. Having established this, it is also important to review critically previous team literature for what it might

contribute to a subcultural analysis of teamwork. It is to this task that we now turn.

Subcultural Analysis of Teams

While teamwork literature to date does not employ a subcultural approach in its evaluation of health care team functioning, it is useful to review the contribution of this literature to my subcultural analysis. This section begins with a critique of the "non-subcultural" literature, follows with a brief assessment of research on medical dominance, and concludes with a detailed evaluation of the studies which can be considered as subcultural in some sense.

Critique of Non-Subcultural Analyses of Teams

The review of team literature indicates that previous research has tended either to produce laundry lists of factors affecting collaborative teamwork or to address only one small aspect of the problem. Little attention has been given to careful definition and categorization of the problems experienced by teams. The result is a fragmentary, inconclusive, and confusing body of data. Even commonly used concepts are often undefined and, as mentioned previously, there is little cross-referencing between different areas (see Bronfenbrenner and Devereaux 1952; Golin and Ducanis 1981; Kane 1975; Nagi 1975). All of these works can be criticized for lacking an understanding of the dynamics of the admittedly complex situation of teamwork. Without a

more focused approach, they cannot explain the process of team conflict.

Perhaps the most telling criticism to be made of previous literature is that by ignoring the work of analysts in other areas, researchers produce work that is too narrow in scope. If, for example, one focuses only on the variable of personality, as did some early analysts of interdisciplinary research teams, the socio-cultural setting of the team is ignored. While sociologists have studied the impact of institutional organization upon behavior in medical settings and social psychologists have examined the role of the individual within a group and upon group behavior, both can sometimes be critiqued for emphasizing the importance of role at the expense of the socio-cultural setting. It is useless to discuss organization in and of itself without examining the larger society in which the organization is set.

The program evaluation literature and the writings of anthropologists considering the researcher in a clinical setting are also lacking in scope (see Leighton 1972; Richards 1970; Rodman and Kolodny 1971; Weiss 1977). Merely describing problems of adjustment is not sufficient. What is necessary is explanation of the origin of collaborative problems. In sum, team literature can be criticized as disjointed insofar as it covers only one small aspect of the

problem. Previous studies lack an integrated consideration of all levels of team collaboration, from personality, to role, to the wider socio-cultural setting in which teams are shaped.

Treatment of Medical Dominance in Team Literature

Since medical dominance surfaces as an item of concern in nearly every article and book mentioned in this review, it merits special attention. Physicians have always been dominant within health care teams (Freidson 1970a). Because of their long years of training and the serious nature of their work, doctors have always been accorded the greatest amount of responsibility in health care and have been rewarded with the most status, autonomy, money and power (Peeples and Francis 1968; Szasz 1969). It should also be noted that this tendency has been seconded for years by federal and state statutes regarding licensure and recertification, malpractice insurance and the legal right to prescribe drugs. It is not surprising, then, that physicians might expect to make decisions for an entire team.

Present-day teams are often criticized for being physician-dominated, and thus having a medical bias. Attacking physicians as cold and removed and therefore incapable of providing holistic health care (Wise 1975), critics argue that the physician should not be "the central figure in the health arena" (Hiatt 1975:263). Indeed, obstacles to

teamwork are sometimes directly attributed to physicians. It has been suggested that doctors have a "trained incapacity" for change (Geiger 1974:554) and that they resist changing from entrepreneurial to organizational forms of medicine (Menke 1971).

Most modern teams strive for collegial relationships between members. The literature demonstrates that the issue of equality, however, has not yet been settled. Many analysts argue that all team members must respect each other's area of competence before teams may operate successfully. This may require a flexible relationship in which task determines leadership (Rubin and Beckhard 1972), and it necessarily implies a kind of equality not traditionally found in medical settings. Unfortunately, team members are not always willing to recognize each other's competence (New 1968). As a result, it often falls to marginal disciplines to demonstrate and win respect for their expertise and judgment (Richards 1970).

Continuing concern over the issue of medical dominance is demonstrated by the fear of some sociologists that medical sociologists have been or will be co-opted by the medical model. This apprehension is probably a spin-off of Roth's criticism of sociology as having a management bias, that is, with being produced in support of medical practitioners rather than of consumers (Johnson 1975). Radical

sociologists have gone a step further, critiquing the health care delivery system as an agent of social control (Gouldner 1971; Pflanz 1975).[6]

Several sociologists have also blamed the paucity of medical sociological theory on medical domination (Gold 1977; Johnson 1975). In accordance with these changing perceptions of medicine, David Sims has recommended that researchers change their focus of investigation from problem solution to problem definition and has suggested that those in power have undue influence over the definition of problems (1979). Traditional hospital settings have been described as being "caste-like," with staff members interacting mostly with those of their own occupational group and with doctors, nurses and ward workers holding three basically different ideologies concerning the purpose of the hospital (Wessen 1972). When the rigidly defined groups that exist within hospitals are different with regard to goals, communication and role and authority, it is easy to understand the barriers to teamwork which might result.

Critique of Earlier Subcultural Analyses of Teams

While team conflict and medical dominance have been identified as the key issues in team operation, to date no coherent analysis of these issues has been forthcoming. Almost all of the teamwork analysts mentioned earlier in this chapter discuss the difficulties encountered when

members of one profession or discipline attempt to work cooperatively with those of another. They do not, however, discuss these conflicts in terms of subcultures. Instead, they blame inadequate preparation for teamwork and point either to the process of professional socialization or to the lack of teamwork exposure afforded by traditional training.

Social science researchers, for example, define problems of interdisciplinary teamwork as being caused by disciplinary or professional socialization. Professional socialization is identified as a problem because it develops professional commitment at the expense of subsequent ability to interact cooperatively with members of other disciplines (Frank 1961; Fry and Miller 1974; Geiger 1974; Nagi 1975; Rodman and Kolodny 1971; Simmons and Davis 1957; Sims and Bauman 1975; Young 1955). Training, it is argued, determines perception by specifying the phenomena to be observed as well as the manner in which observations are conceptualized into a theoretical framework. Education also determines behavior by prescribing the methods to be used in studying what one perceives.

In focusing on training, these social scientists highlight the ethnocentrism of disciplines. Each academic discipline, they note, is rigidly separated from the next with little if any overlap. It is an arrangement which

actually discourages interdisciplinary pursuits (Campbell 1969). Disciplines school students in their own special languages, and the result is an esoteric jargon for each profession. Cross-disciplinary communication is a monumental problem (Horwitz 1969). Individuals who cannot communicate cannot appreciate or respect each other's approach and have difficulty in developing the common outlook necessary for joint team efforts.

Additionally, social science investigators note that traditional disciplinary training provides no model for cooperative efforts. Instead, disciplines train their members to operate in a highly individualistic and competitive manner as "lone wolves" (Eaton 1951:708). This also discourages collaboration and causes those who do work in teams to experience problems in keeping their professional identity while attempting to contribute to team process (Menke 1971; Richards 1970; Szasz 1969). The same difficulty has been noted in the professions, where physicians who engage in teamwork move from the entrepreneurial orientation of private practice into an unfamiliar cooperative setting (Menke 1971).

Both professions and disciplines also have certain expectations of their members which may run counter to the requirements of teamwork. Those who work in academic settings must sometimes revise their expectations of applied

members in their discipline.[7] Team members, in turn, must often loosen the ties with their discipline because the stronger these bonds the more difficult the development of team loyalty. Even traditional ideas of privacy and confidentiality work against the concept of a team (Rubin and Beckhard 1972). While the doctor-patient relationship is expected to be "private" and the therapist-client relationship to be "confidential," teamwork necessarily violates these norms.

Models for egalitarian teamwork are rare in American society. The precursor of modern teams, the traditional doctor-nurse team, is not a team at all, but a highly-structured arrangement between a physician-leader and subordinate nurses, perhaps more akin to the model provided by an executive and his secretary.[8] American sports teams also offer a non-egalitarian, hierarchical model. The coach runs the sports team much as a physician directs the traditional medical team. He tells the players how to perform and what plays to execute. The coach's plans and set plays are much like the standing orders a physician might leave with a nurse practitioner and the players operate within a very strict, authoritarian framework. Like the doctor, the coach is referred to by his title: Coach X.

In general, American culture is characterized by its individualistic orientation. Americans would never call

themselves collectivistic; rather, they often seem to fear "collectivism." The strong strain of individualism in American society is a powerful inhibitor of collaboration, evidenced by the fact that Americans tend to resist joining forces to affect social planning (Dyckman 1969).

Finally, consumers have certain expectations concerning the packaging of health care which seem to run toward fantasies of a genial, all-knowing, personal physician who makes housecalls at night--the model of television's "Marcus Welby." They certainly do not expect treatment by a "team" of gathered mental and physical health care experts. It is also possible that consumers, when faced with a team arrangement, expect the physician to be in charge (Peeples and Francis 1968; Szasz 1969). It has been argued that health care team members may have similar attitudes, thus forcing the physician into a position of responsibility he does not necessarily seek (Pflanz 1975). It may, then, be a reflex action for team members to "follow the doctor" (Rubin and Beckhard 1972:327).

Medically oriented analysts of teamwork in health care settings tend to point to lack of team exposure as the guilty culprit in producing problems of team collaboration (Fry and Miller 1974; Jones and Dunn 1974; Kindig 1975; MacDougall and Elahi 1974; Mason and Parascandola 1972; Peeples and Francis 1978; Szasz 1969). In contrast to

social science commentators who point out that training provides socialization in one narrow area of specialization, these medically oriented writers focus on what training does not offer: exposure to other professions through teamwork experience.

It should be noted that while social scientists are busy defining the problem as socialization, medically oriented commentators have already moved on to propose exposure to teamwork as the solution. Each might be criticized: the social scientists for being unconcerned with the practicalities of problem resolution, the medical scientists for jumping into solutions before the problem has been fully defined. This distinction in orientation between medical and social science personnel will be raised again in Chapter VI.

The analyses discussed to this point are incomplete because they do not diagnose the problem of team conflict with sufficient care. They discuss a process of differentiation between disciplines without naming or discussing the professional subcultures responsible for generating these differences. Although several articles mention the differing "cultures" produced by disciplines and professions (Nagi 1975; Richards 1970; Rodman and Kolodny 1971; Rubin and Beckhard 1972; Sims and Bauman 1975; Young 1955), they do so only in general reference to the fact that team

members come from different educational backgrounds.[9] They do not discuss the specific impact of professional subcultures on team process. When they focus only upon the way in which training is structured, they do so at the expense of understanding training content. In this way they overlook the formation of subcultures and their impact on the behavior and attitude of individuals engaged in teamwork.

Some studies adopt a more explicitly subcultural orientation, and are, therefore, more valuable contributions to our understanding of team functioning. Although he does not directly address the issue of teamwork, C.P. Snow offers useful information on subcultural differences between disciplines and professions. In his classic work, The Two Cultures and the Scientific Revolution (1961), he describes the existence of two totally different and mutually exclusive cultures in Western civilization:

> [the] literary intellectuals [are] at one pole--at the other scientists . . .. Between the two a gulf of mutual incomprehension--sometimes (particularly among the young) hostility and dislike, but most of all lack of understanding. (1961:4)

Snow notes that members of each culture can easily understand one another: "Without thinking about it, they respond alike. That is what culture means" (1961:11). They cannot, however, understand individuals of the other culture. Because they cannot talk to each other, each lacks knowledge

of and respect for the goals and achievements of the other culture.

George Foster takes this type of cultural analysis one step further in his discussion of cultural distinctions between disciplines and professions (1962, 1969). In reviewing problems of cooperation encountered by administrators and anthropologists working together in action research settings, he refers to a "subcultural chasm" between the two groups. Foster believes this gap to be directly related to differences in values, methods and goals between the administrators, who are drawn from professional schools of training, and anthropologists, who have received disciplinary training. He briefly discusses the influence of disciplinary and professional affiliation upon the process of team collaboration. Anthropologists, for example, are perceived by Foster as valuing knowledge and pursuing theoretical research as a goal. Administrators, on the other hand, are held to prize the achievement of organizational goals and to seek problem-solving action as a goal. In making such a firm distinction between research and action, Foster tends to exaggerate, probably for the purpose of analysis. Nevertheless, it is a useful distinction which offers a framework for examining the subtleties of subcultures in more detail. The difference between the medically-oriented professionals and the social scientists with

disciplinary affiliation is of major importance within the CHP team and will be examined in depth in Chapter VI.

David Banta and Renee Fox (1972) have produced a useful study on the professional functioning of the health care teams formed in the first Office of Economic Opportunity Health Center in Columbia Point in Boston. They interviewed the physicians, social workers and public health nurses who were members of these health care teams. Analyzing differences in values and goals among professional groups, environmental and institutional stresses experienced by staff and methods used for coping with stress, they concluded with a discussion of the manner in which each group viewed the professional functioning of their own and of other groups.

Although the article is quite useful in providing an idea of the strains experienced by professionals attempting cooperative teamwork, it does not adequately address the process of team conflict. The authors discuss the problem of role definition but do not adequately explain the source of the "multiple group tensions" experienced by team members. Furthermore, while they note that the teams were intended to be egalitarian, that physicians tended to assume team leadership in spite of this, and that there was a lack of peer relationships within the teams, they make these observations in a cursory and disconnected manner. The result is

a provocative but confusing article which does not adequately explain the process of team conflict.

Adrian Furnham, David Pendleton and Charles Manicom (1981) also discuss the perception of different occupations within the medical profession. Under the assumption that members of different occupational groups perceive each other in characteristically different ways, they tested the hypothesis that those groups who perceived their traditional field of knowledge, style of operation, or client groups as being appropriated by yet another group would appraise that second or out-group unsympathetically. By asking 125 professionals in medical and allied health services (nurses, occupational therapists, health visitors, doctors and social workers) to rate twelve professions, they found this to be true and concluded that separation into occupational groups appears to trigger the psychological mechanism of intergroup prejudice. Their work provides a very useful orientation by linking the psychological reaction of team members to group affiliation. They do not, however, discuss the particular impact of these stereotypes in affecting role performance on a working team and in inhibiting the process of day-to-day collaboration. What is needed is a more in-depth study of the source, nature and consequences of the stereotypical and prejudicial perceptions of one profession by another. In the case of the CHP team, we must also consider the addition

of academic disciplines to the more traditional medical and allied health professions.

June Huntington (1981) also deals with small groups in dissecting "inter-occupational differences" between social workers and general practitioners involved in collaborative efforts. Although she does not specifically refer to this organizational arrangement as teamwork, the two occupations do interact in a teamwork situation. Huntington lists ten "cultural" and eight "structural" variables which she maintains affect inter-occupational relationships. She notes that differences in time orientation relate to three of these eighteen variables and function to inhibit collaboration.

Her article is useful in that it thoroughly documents the existence of occupational differences and demonstrates awareness of "cross-cultural differences" (1981:208). Her conclusions with regard to time orientation support my own. Less useful is her theoretical framework. She presents a shopping list of social and cultural factors without indicating their relative importance or the relationship among them. She needlessly complicates the analysis of "conflictual rather than collaborative" relationships (1981:208). My inquiry into the CHP team attempts to analyze the problem of team collaboration through a less complex but more

focused treatment of subcultures which may form within a team and which may be composed of one or more occupations.

A final useful approach to team analysis has been produced by those who consider teams as small groups. In his book, The Sociology of Small Groups (1967), Theodore Mills, for example, discusses small groups from the vantage point of a newcomer moving through certain stages in coming to accept a group as his own. In highlighting the induction of new members into small groups, Mills focuses on the juncture between individual/emotional experience and group experience. Although he stresses the importance of socio-cultural context, he does not explore it; instead, he prefers to focus on the individual.[10]

Because of its emphasis on the fit between individual and group behavior, Mills' analysis provides an excellent means of understanding the induction of an individual into a relatively cohesive group. In dealing with team conflict, however, we are not dealing with homogeneous groups. In interdisciplinary/interprofessional teams, we have situations in which disparate groups are forced into cooperation. Team situations involve a predictable amount of disharmony. It is more analytically powerful to approach the problem of discord by examining the juncture between the group and the larger socio-cultural setting from which its members are drawn than to look at the joining of the individual and the

group. This brings us to a focus on culture, or more specifically, to a focus on subcultures which form within teams.

Summary

Despite the growth of interest in teamwork, team conflict and medical dominance have been serious obstacles to effective collaboration in modern health care teams. Unlike the traditional hierarchical doctor-nurse team, modern interdisciplinary research teams, interprofessional clinical teams and interdisciplinary/interprofessional teams expect collaborative work relationships as an integral part of providing comprehensive services to consumers. Such collaboration does not appear to be forthcoming.

Research on such teams to date reveals collaborative difficulties but tends to be too narrowly focused. Investigations of interdisciplinary research teams, for example, concentrate on the negative impact of personality and emphasize the difficulty team members experience in attempting to understand methodological and theoretical differentiation between disciplines. In contrast, examinations of clinical health and human service interprofessional teams tends to be of four types: (1) "try it, you'll like it" exhortations, (2) descriptions of particular teams, (3) brief sociological analyses focusing on roles and (4) general tracts written for or by social workers who will be working on teams.

Finally, research on interdisciplinary/interprofessional teams highlights problems of adjustment experienced by academic researchers as they move into clinical work settings. In each case these discussions tend to ignore the work of researchers in other teams and tend to fail to offer a coherent theory of teamwork. What is lacking is an integrated consideration of all levels of team collaboration, from personality, to role, to the larger socio-cultural setting.

In developing the methodology of this study, I critically reviewed previous team literature. It was evident that no ethnographic study of teamwork existed and that the literature often tended to be contradictory. To overcome the methodological weaknesses of teamwork literature, I carefully reviewed applied anthropological research in search of an approach which would provide more accurate results. I adopted a subcultural and qualitative methodology because of its advantages in this particular research setting. By examining the fit of individual team members within the socio-cultural setting of the Children's Health Program team, this study provides a unique approach to health care team analysis as well as an evaluation of the problems of team conflict and medical dominance which have plagued the operations of health care teams.

My basic criticism of teamwork literature is that it bypasses subcultural analysis of teams in favor of blaming conflict either on disciplinary training or on the lack of opportunity for joint educational experiences between members of different professions. Too often, team analysts have focused on the manner in which training is structured at the expense of understanding the content of that training. As a result, they overlook the significance of subcultures and their impact upon the process of teamwork.

A few researchers do attempt a more specifically subcultural analysis of team conflict, but either do not pursue this issue in sufficient depth or needlessly complicate the question. C.P. Snow (1961) and George Foster (1962, 1969), for example, discuss subcultural differences between disciplines and professions but do not elaborate sufficiently to allow a dynamic understanding of this process. David Banta and Renée Fox (1972) discuss the "strains" inherent in cooperative teamwork but confuse the structural concept of role definition as an explanation for the process of team conflict rather than viewing it as a symptom of underlying problems of subcultural conflict. Other researchers also fail either to offer a comprehensive vision of team conflict (Furnham, Pendleton and Manicom 1981; Mills 1967) or complicate our understanding of team conflict by listing too many influencing factors which are not integrated in a

comprehensive and understandable manner (Huntington 1981). In spite of these shortcomings, team literature does provide a foundation upon which to build. By combining the strengths of the previous literature with my own anthropological orientation, I was able to adopt a methodology well suited to analysis of the CHP's interdisciplinary/interprofessional health care team.

To date, there has been no sufficiently holistic study of the problem of teamwork and teamwork functioning. This study, by focusing on the relations between professionals in one particular interdisciplinary/interprofessional health care team, the Children's Health Program team, attempts to remedy this lack. It demonstrates how the concept of two subcultures helps to make observations of teamwork more understandable. The minute examinations provided by a case study of the day-to-day functioning of one team make it possible to understand the roots and process of team conflict, the oft-mentioned but never-explained obstacle to teamwork.

Notes

1. The names of the city, the physician and all other participants have been changed in order to protect confidentiality.

2. While there were only sixty health professionals trained in other fields for each one hundred physicians in 1900, by 1960 there were 371 (Cohen 1971).

3. Traditional evaluation research emphasizes quantitative analysis, to the exclusion of qualitative approaches, in measuring the achievement of program goals. The classic Fisherian experimental design is held as the research ideal (Houston 1972). Evaluation research involves the use of experimental research design, when an experimental and control group are randomly selected. The experimental group is subjected to treatment while the control group receives no treatment, and variability between the two groups is then estimated. Many program evaluators consider experimental research to provide the most powerful means of testing social action programs (Rossi 1972). In what have been called the "bibles" of evaluation research, Donald Campbell and Julian Stanley (1966) and T.C. Cook and Donald Campbell (1975), in a revised version of the same material, compare all research designs unfavorably to randomized controlled experiments.

4. Many general books deal with problems of conceptualizing and executing evaluation research. See, for example, John Heilman (1977); Herbert Hyman and Charles Wright (1971); Peter Rossi, Howard Freeman and Sonia Wright (1979); and Carol Weiss (1972). These books are written by program evaluators who outline and suggest means of overcoming the problems inherent in quantitative program evaluation. They do not suggest qualitative approaches as an alternative.

5. Anthropologists have traditionally had little exposure to or training in quantification. Anne Roe, in discussing the differences between anthropologists, psychologists, biological and physical scientists, noted that of the four, anthropologists held both the least interest and lowest ability in mathematics (1952, 1953).

6. P.M. Strong counter-attacks by accusing sociologists of producing "exaggerated" reports of medical dominance (1979:200) because of their own imperialist ambitions. He points out that a social model of health would provide

   an even better vehicle of oppression than that already offered by organic medicine.

7. For example, applied work often does not leave sufficient time for research and publishing, the two areas which academics evaluating each other often judge as most important.

8. The absolute fear by some physicians of sharing this traditional power is revealed in the attack of a physician-psychiatrist upon those physicians who engage in egalitarian teamwork. He accuses his colleagues of giving sway to their "passive defenses and feminine identifications" (Berlin 1970:147).

9. Of these, Young makes the strongest case for analyzing "subcultures," stating that such an approach is "the key" to success in teamwork (1955:647). His comments, however, remain general.

10. Mills identifies a major advance produced by small group studies as being the reduction of "the trichotomy between the individual, the group, and society" (1967:9). The individual is now viewed as being both "in the group and of society" (1967:9). He refers to "group culture" in discussing a group's beliefs and values, defining it as "the set of shared (explicit and implicit) definitions of reality; preferences among objects, ideas, and states of affairs; and standard procedures for pursuing the desirable--all as collectively defined" (1967:95). He does not, however, discuss group culture in detail.

CHAPTER II
TEAM HISTORY AND FIELDWORK SETTING

My memories of the town of South City are idyllic: early morning light, green lawns, the sharp freshness of a high blue sky, moist sea air breezing gently through the day and lights, soft twinkling lights, rimming the bay on which South City perched and a sprinkling of yet more lights under the high arching causeway on which motorists entered the city. These tranquil, peaceful images could not contrast more sharply with the stressful, anxious days I spent as a staff member on the CHP team. Dissension was rife on this team, manifested most strongly in the open expression of hostility between team members. As startled as I was to discover a team filled with strife, a review of team literature persuaded me that the CHP team was not an exception.

As the review of the literature in the previous chapter indicates, collaborative problems in teams are more the norm than the exception. Given the fact that the "team approach," particularly one utilizing both social science and medical personnel, is innovative, problems of cooperation within the CHP team could have been predicted from the first. During my tenure with the CHP, from October, 1974, until July, 1976, the creation of a collaborative team

relationship proved elusive.[1] The intent of the program was to provide an interdisciplinary approach to health care through teamwork. The outcome was a team in which the medical members busied themselves with clinical work and the social scientists restricted themselves largely to research. The two groups remained segregated. There was much friction between team members and although the situation changed somewhat as communication improved, the experience was a difficult one for those involved.

This chapter orients the reader to the subject of this study: an operating, interdisciplinary/interprofessional team. It includes an outline of the team's historical background, a brief description of the fieldwork setting between the research years from 1974 until 1976, and an assessment of the effect of the first anthropologist's presence prior to 1974. The chapter concludes with a discussion of the reception subsequently afforded the first anthropologist's "replacements," the second anthropologist (LCI) and the sociologist.

CHP Team History

The CHP team received its first funding in September of 1972. Before that date it had existed only as the dream-child of Dr. X. Practicing as a South City pediatrician, Dr. X was bored with general practice, uncertain of how to handle the "behavioral problems" he encountered in his

patients, and generally lacking in what he called "self satisfaction." He left South City to undergo additional training as a subspecialist in pediatric cardiology, returning in 1967 as Director of the Department of Cardiology in the Children's Hospital.

Dr. X, however, felt "lonely" in South City and complained that the area was "intellectually dead." More serious was the fact that the population density of South City was not high enough to support his practice as a pediatric cardiologist. In 1968 he began to travel to the outlying areas of South City, known locally as "the Basin," in order to secure patients. Dr. X was accompanied by the hospital EKG technician who was later to function as the "technician-administrator" of the CHP team.

His difficulty in maintaining a practice caused Dr. X to become interested in large-scale screening programs which would funnel children with congenital heart disease into his practice. In 1969 he applied for local funding to support such a screening project but was turned down. During the process of application, Dr. X developed the idea of training nurses for an expanded role in providing health care. Intrigued with this new notion, he saw the use of such nurses, who would also be Mexican American, as a possible solution to the "cultural problems" he found himself facing in the Basin with his now largely Mexican American clientele.

Beyond problems of communication with non-English speakers, the issue of specific concern was patient compliance: "Why people wouldn't take my advice about medical management."[2] Dr. X had also become aware of "the complete insensitivity within the hospital to the cultural needs of the patient." Children's Hospital employees, for example, were not allowed to speak Spanish to patients of Dr. X who had been hospitalized for catheterization or open heart surgery.

During this same time period, Dr. X met a medical anthropologist. Coming to believe that "others besides the physician were important," he was "excited" by the prospect of including an anthropologist as "someone who could understand people." Dr. X believed medicine to be too biomedically oriented and was interested in increased interchange between the medical and social sciences. "In medicine," he once commented, "we've left out a great deal of man's behavior." Dr. X was also exposed to representatives of the local mental health center and was "talked into" adding a psychiatric social worker to his grant request. He noted: "I had no idea what the psychiatric social worker would do other than shed some light on different cultures. I guess I picked the anthropologist already knowing what he would do."

In 1972 Dr. X submitted a new grant application containing staff positions for himself, the "EKG technician-administrator," expanded-role nurses, an anthropologist, and

a psychiatric social worker. This proposal was funded by a Regional Medical Program grant of locally-disbursed federal money. Between the months of October, 1972, and January, 1973, he hired the new staff members. Although the grant stipulated that master's level Mexican American nurses be hired for training in pediatric cardiology, none was available. Instead, Dr. X secured three Mexican American nurses with diploma or Associate of Arts degrees. Between 1972 and 1974 two of the original three nurses, both female, resigned, leaving behind one male nurse. Two new male Mexican American nurses were then recruited and trained.

Although the original grant had been awarded for a three year period, the program lost this funding within its first months of operation as a result of federal budget cuts. The program then found it necessary to seek funding on a yearly basis, first receiving Organization for Economic Opportunity (OEO) funding and later funding from private foundations and federal and state agencies.

In addition to these unexpected problems with funding, Dr. X encountered further difficulties in directing grant administration and managing program staff: "I couldn't watch over everybody; I didn't have enough time." A secretarial position ("secretary-coordinator") was added in 1973 to help in this regard.

The program was only sporadically staffed prior to 1974 by a psychiatric social worker in several part-time and full-time arrangements. The first anthropologist was hired in November, 1972, and remained with the program until the summer of 1974. A newly graduated Ph.D., this Anglo anthropologist was from the Northeast and had several years of living and fieldwork experience in Mexico. In addition to providing a new social science perspective to the solution of medical problems, the first anthropologist taught the physician about the cultural background of his Mexican American clients, particularly as related to their beliefs and actions as medical patients. As the physician's wife noted:

> The first anthropologist educated Dr. X in what the Mexican American was like. He learned a great deal from the first anthropologist that the nurse practitioners wouldn't know to tell him. The first anthropologist was a student of this sort of thing and he taught Dr. X how to relate to the Mexican American patients.

The position of economist was added to the team in 1974 after the program was criticized by a local grant review board as "inefficient."

Field Setting

When the research for this study was first begun in October of 1974,[3] twelve full-time and part-time staff members from the medical professions and social science disciplines made up the CHP team. The full-time team members, listed in the general order of their entry into the program,

included the "director" of the program, a pediatric cardiologist, also Director of the Cardiology Department of the Children's Hospital; a technician-administrator, also chief of the EKG-EEG staff at Children's Hospital; four Mexican American nurses, certified as nurse practitioners and "pediatric cardiology associates," the newest of whom and only female was still in training; a secretary-coordinator; a social worker; a sociologist; and an anthropologist. The team also employed two part-time members, an economist and a "public relations consultant."[4]

Of all the team members, the social scientists were the newest. The economist had begun his association with the program during the previous spring. He lived in a large city, 200 miles distant, and commuted to South City once a week. The second anthropologist was new not only to the CHP but also to the community, having just moved to South City to take the CHP position as program anthropologist. The sociologist was a native of South City. He had been employed for roughly one month before the anthropologist arrived, had quit citing a chronic health condition as the reason, and, after being absent for several weeks, had renegotiated his employment with the CHP. The male, Mexican American social worker was from a large city north of South City. In order to work with the CHP team, he had moved to

the community of South City several weeks before the arrival of the anthropologist.

The physician, founder and director of the team, was a subspecialist in pediatric cardiology. As there was virtually no rheumatic heart disease in that area of the Southwest, the physician was concerned with diagnosing and treating congenital heart disease.[5] The physician was trained[5] to perform cardiac catheterization, a diagnostic procedure in which the chambers of the heart are probed with a catheter inserted in the femoral artery. Pediatric cardiologists do not perform corrective surgery but are, however, responsible for continuing care after surgery.

The nurses assisted the physician in his efforts to diagnose and treat heart disease. These nurses received eight months of training from Dr. X in various aspects of pediatric cardiology and child health care. They took an additional four months of training in a nurse practitioner program located at a university 230 miles from South City.

In their expanded roles, the nurse practitioners met with the patients prior to Dr. X. They gave physical examinations and took medical and social histories. Combining this information with their interpretations of EKG, X-Ray and laboratory tests, they produced a preliminary diagnosis attempting to "detect and interpret heart murmurs." Their

work was considered to be "under the supervision of the physician" and, when completed, was reviewed by him.

Dr. X was responsible for diagnosing the patient and organizing plans for patient management. The nurse practitioners were the ones to carry out these plans, explaining medical actions to the patient and his or her family. The rationale behind this arrangement was, in the words of the physician: (1) "the nurse practitioners will carry our services to a larger number of needy children," and (2) "this arrangement permits the physician to allocate his time more efficiently."

The technician-administrator performed necessary medical tests such as EKG-EEG, ear oximetry and vector-echocardiogram. She was also responsible for bookkeeping and other clerical-administrative functions. The secretary-coordinator was charged with ensuring intra-team coordination in addition to her secretarial work. Social and emotional care not provided by the physician or nurse practitioners was offered by the social worker. The anthropologist and sociologist were to research program/health concerns and to teach social science to medical personnel. The public relations consultant raised program funds and the economist oversaw the program's fiscal management. These descriptions are simplified and obviously overlapping--an issue which will be dealt with at further length in Chapter VI.

It was the goal of the CHP to provide multidisciplinary health care by diagnosing and treating children with congenital heart disease. The program's clientele was drawn from an impoverished area of the country where 40.7 percent of all families fell below federally established poverty lines. Of those patients seen by the CHP team, 86 percent were Mexican American, 11 percent Anglo, and 3 percent black. The median income of these families fell between $200 and $300 per month.

This largely indigent, Mexican American population was spread over an area of 24,000 square miles. Operating from a South City base, the team covered this 22-county area, the Basin, with a system of 11 satellite clinics,[7] each of which was visited monthly or bi-monthly. Patients requiring complex diagnostic procedures, intensive care or surgery were referred to the Children's Hospital in South City for further diagnosis and treatment.

A 90-bed pediatric hospital, the Children's Hospital was founded in the 1950s as a charity institution intended to provide hospital and outpatient care for indigent children in a 39-county area surrounding South City. When this study began in 1974, the hospital had become a not-for-profit operation. The hospital offered the only pediatric subspecialty care in the region and housed the offices of the CHP team.[8]

Within the Children's Hospital the nurse practitioners made daily ward rounds of all in-hospital patients, acting as "physician-delegates." In doing so, they monitored patients, explained treatment and solved "non-medical" problems. They carried out plans which had been formulated and delegated to them in the daily patient management meetings. The nurse practitioners also saw patients during the thrice weekly outpatient screening sessions held in both the South City Children's Hospital and the Basin, trained public health nurses to do screening for heart murmurs and taught hospital residents about cardiology.

One of the three nurse practitioners was stationed in a town in the Basin and the nurse practitioner in training was slated for similar outpost duty in another town. Working through the local public health department, these nurse practitioners were to screen and perform a preliminary evaluation of clients with suspected heart murmurs[9] who would then be "reappointed for final medical diagnosis." They also provided follow-up for known cases.

The First Anthropologist

In the fall of 1974, the early days of the sociologist and second anthropologist were punctuated by constant reference to the unacceptable ways of "your predecessor." The first program anthropologist was cited as not having been

"accepted by hardly anybody."[10] As one medical professional complained with feeling:

> We all felt like an individual with a lot of education came in and kind of put us down and he was a person we didn't see utilizing his time efficiently or really doing anything. I think we all perceived social scientists as people who came aboard and sat around talking instead of doing.

There was some awareness within the program of the problems of role definition which the first anthropologist might have encountered in attempting to define a place for himself on the team. Dr. X was particularly sensitive to this issue:

> I really wanted the first anthropologist to find out what his role was. I didn't know! He was only the second anthropologist I ever met. I didn't know anything about anthropology, couldn't have written a job description if I'd wanted to. I can understand how the first anthropologist might have felt confused about the same thing.

The more usual reaction within the team was for the first anthropologist to be regarded as responsible for his own lack of acceptance. His status as an anthropologist then produced an additional sore point. As a medical team member declared:

> I originally thought an anthropologist must be someone who could go out and live with the natives: eat out of the same plates, sleep on the same bed, get their hands dirty and be accepted. With the first anthropologist, we were involved with an individual who just couldn't do that in this setting, who just couldn't get his hands dirty. It was kind of a let-down when you expect an anthropologist of all people to be able to adapt to the culture of the team.

More specifically, the first anthropologist was also criticized by the nurse practitioners for his interactions with the hospital power elite:

> He ended up hanging around with just the big wheels in the hospital. He didn't want to hang around the low people. He stated he wanted to work with "the people" and turned around and did the opposite.

The first anthropologist was familiar with these complaints and refuted them:

> They thought that I was somehow feathering my own nest and that I was trying to build a power base. They never questioned their own assumptions because that's what they would have done if they had been in my position.

Another area of difficulty was posed by the first anthropologist's vocabulary. Early in her stay with the CHP, the physician gave the second anthropologist a letter written by the first anthropologist and requested a "translation." He complained: "I have a hard time understanding what he writes. I've often been unable, after talking to him, to say just what exactly we did talk about." Even the second anthropologist had some difficulty working through this letter, but with diligent application was able to produce a translation into plain English. The physician remained distressed by the first anthropologist's use of words:

> It was just verbiage, anomalous verbiage. You don't know what all that stuff means; you just sit there and it inundates you. To what purpose?

> He's not teaching me anything. It just drowns me. I can't even follow it to question it.

In such instances one might conjecture that words had become the first anthropologist's instrument of reprisal. In a setting in which he perceived no support, he may have honed words into the weapon of verbiage. It was perhaps a pleasant form of revenge, as it obviously left medical personnel reeling in its wake. All of this, however, did not change the medical view of the first anthropologist as "someone who came on board and sat around talking instead of doing." This interpretation is suggested by the first anthropologist's response when informed that the physician was having difficulty understanding him:

> He wants to be spoon-fed. If he doesn't like it, that's too bad. That's the way I give it. If he wants to get into the big time, he'll have to improve his vocabulary.

In all of this, of course, the first anthropologist armed his fellow team members with a verbal axe handle to use on his successors.

The "New" Social Scientists

Because of "difficulties" they encountered in dealing with the first anthropologist, medical team members assumed the situation would be identical with all social scientists. The following quotation from a nurse practitioner summarizes the worst of the sentiment against the social scientists:

> The person that sponsored you was not very well received here. As long as the social scientists come sponsored solely by that individual, and in your case he was the chief locator, coordinator and expressor [sic] of how it was going to be, then it's a tragedy. The first anthropologist had so many problems that anybody he selected had to have some problems of their [sic] own, something wrong with them [sic] too, to make the first anthropologist say: "You're a good person for the team."

Or, as another nurse practitioner noted sympathetically:

> When you first came here you came in someone else's shoes. You were already judged and sentenced before you even got started.[11]

The first anthropologist was also aware of this hostility and stated apologetically: "I pre-socialized [sic] the medical personnel against you."

Reactions of distrust and dislike expressed toward the first anthropologist were thus visited again on the new social scientists. Team members were aware of this process:

> Problems when you first came were our fault because we didn't accept you like we should have. I guess we were upset because the first anthropologist would come in whenever he damn well pleased and leave when he wanted to. You never knew when he was going to be here or if you could depend on him. I guess all of us were skeptical wondering if this was going to start up all over again with you. I thought: "I hope it's not another first anthropologist." You know that wasn't fair.

As the previous quotations indicate, the sociologist and second anthropologist were accorded a frosty reception. This strained atmosphere was relieved on occasion by the periodic supportive interventions which the project

director, Dr. X, made on behalf of the social scientists. As the team member who initially conceived of using social scientists as members of the medical team, he was their most enthusiastic proponent. On the whole, however, the reception and treatment of the social scientists during their initial months with the CHP was cool indeed. A medical team member later noted:

> When you first came, very few people would even talk to you. To tell the truth, we don't welcome new people with open arms around here. We seem to want them to prove themselves before we accept them and we don't go out of our way to help them either.[12]

In a similar vein, another team member explained this situation to a program outsider: "The social scientists didn't know what to expect. They walked into a bad situation on eggshells."

An already difficult situation was then complicated by the social scientists' response. They marshalled their joint forces by banding together. Spending much of their time in their office, they attempted to figure out what was happening and to discover its cause. This gave team members further reason for alarm: "I got the feeling at first that you two were getting together and yakkity yakking, saying 'Just to heck with that bunch, we're going to do our own thing.'" As another noted: "You people can't do that because you're setting up a new power structure. You should know no one will stand for that." In addition, feelings of

anxiety inhibited interpersonal communication between the anthropologist and sociologist and their fellow team members. As a team member later commented: "The sociologist came on strong and it drove them off and the anthropologist was very shy and they didn't know how to approach her."[13]

The social scientists were in a self-described "state of shock" at their reception by the CHP team. The sociologist saw the team setting as "very hostile." The anthropologist concurred, further stating: "I can't believe this. If this is applied anthropology, I'm going to change fields." The economist criticized other team members for not accepting the anthropologist and sociologist, pointing out the negative effect on team productivity:

> I think we can expect that people who are made to feel welcome will perform better. If it's performance we're after, I think it behooves us to treat people well when they come into this team. If people feel interpersonally insecure, there's no way they're going to be innovative. I think we lost about three months of productivity out of the sociologist and second anthropologist during their initial time with us. If they'd been made to feel more welcome, things would have gone much more smoothly.

Summary

The historical background of the CHP prior to 1974 reveals a heritage of "bad will" which often bordered on outright hostility. Initially unaware of the full extent of the negative legacy of the first anthropologist and of the confusion among medical personnel, the new social scientists

found it necessary to adapt to a difficult situation. Even though they eventually embarked on a concerted effort to "make themselves useful" and thus to increase their level of acceptance, problems of teamwork continued. The difficulty, as will be made clear, was not merely one of personal acceptance; rather, it was one of fundamental conflict between the medical and social science approach to health care.

Notes

1. Although this research on the difficulties of team collaboration was completed between 1974 and 1976, the problem of interprofessional rivalry and tension is in no way dated now, in 1983. As Warren Kinston points out in a recent article on interprofessional behavior in hospital settings, "the struggle for status amongst the professions and semi-professions is now a regular part of health politics" (1983:1160). He concludes: "There is considerable friction within most professions and between almost any professional groups that come into contact" (1983:1162). Contemporary collaborative problems are also discussed by Huntington (1981) and Miller & Rehr (1983) in reference to the professions of medicine and social work and by Chrisman and Maretzki (1982) and Kleinman (1982) in reference to health sciences and anthropology.

2. Patient non-compliance with medical directions is apparently a common phenomenon. Mary-'Vesta Marston notes a wide range (from 4 percent to 100 percent) in compliance reported in published reports. She also references M.S. Davis' review of the literature and subsequent estimate that approximately 30 to 35 percent of patients do not follow their doctor's recommendations (1970).

3. I collected the data for this study while employed with the CHP first as a full-time medical anthropologist-team member for nine months from October, 1974, until July, 1975, and then as a consultant (I made monthly return visits of three to five days each from my home base in Mexico City) for the subsequent year from August, 1975, until July, 1976.

4. Some hospital staff members were also associated with the program: EKG technicians, Dr. X's wife, who was in charge of financial billings, and an insurance clerk. These individuals were not considered to be team members and, with the occasional exception of the physician's wife, did not attend team meetings.

5. Training for medical practice as a pediatric cardiologist encompasses nine years: four years of medical school, one year of internship, two years of pediatric residency, and two years as a pediatric cardiology fellow.

6. The eight most common types of congenital heart disease dealt with in the CHP (comprising over 90 percent of the cases) were Ventricular Septal Defects, Atrial Septal Defects, Patent Ductus Arteriosus, Coarctation of the Aorta, Tetrology of Fallot, Complete Transposition of the Great Vessels, Pulmonary Stenosis, and Aortic Stenosis.

7. Of the eleven clinics, eight were held in public health facilities, one in a migrant clinic, and two in the offices of private physicians. The closest clinic to South City was forty miles away; the others were 90 to 140 miles distant.

8. During its first two years of operation, the program encountered many difficulties in the form of administrative fights with the hospital bureaucracy. These "hassles" came in the form of attempts by the hospital administration to limit the team's autonomy and concerned such issues as supervision, salaries, access to medical records and general grant disbursement. In the words of the physician, there was a "war on" between the CHP team and the Children's Hospital. In 1974, when the sociologist and second anthropologist arrived, most of these issues had been settled to the program's satisfaction. Occasional skirmishes continued, but everyone agreed it was "nothing like before."

9. Patients were referred to the CHP by private physicians, public health physicians and nurses and school nurses.

10. The induction of new team members is frequently mentioned in team literature as a time of "stress," for, as time passes, teams begin to have a life of their own which is disrupted by changes in membership. Teams develop and enforce a set of norms (Rubin and Beckhard 1972) and each team comes to have a history which influences the careers of subsequent team members (Horwitz 1969; Lamberts and Riphagen 1975; Richards 1970). As a result, there is

always a period of readjustment with the addition of new team members in which an awareness of the subtleties of team interaction will aid the newcomer (New 1968).

Mills (1967) discusses the induction of a new member into a small group in detail by relating the subjective experience of the group's individual members to the five levels on which group process occurs. A "stranger" to a group begins to operate first on the level of behavior and feelings. He does this by watching others for cues and by modeling the behavior of those around him. The next level of integration into the group comes when the newcomer learns the "rules," or group norms, which stand behind the group's behavior and feelings. The following stage of joining the group involves the newcomer's understanding and accepting group goals to the point of placing them above personal goals. Finally, the newcomer adopts group values, an action encompassing an overarching concern for the welfare and survival of the total group.

11. Such awareness did not mean that team members had necessarily freed themselves of the influence of history. As the physician noted two-thirds of the way through the nine month contractual period of the new social scientists: "A great deal of the way I feel is still colored by my exposure to the first anthropologist."

12. On another occasion she explained our position to an outsider:

> They were new in the program and didn't know what to expect. I think they felt like they were just left out in the cold. Nobody offered to help them, nobody made any effort to invite them in or help them feel like part of the team.

13. In all these actions, the social scientists were seen as "uncooperative." This is demonstrated in the following statement made by a medical team member after the social scientists had been with the program for some months: "You have improved, you are not so demanding." This issue will be further dealt with in Chapter V.

CHAPTER III
THE CHOICE OF METHOD OF STUDYING TEAM FUNCTIONING

The purpose of this chapter is to discuss the rationale for choosing a qualitative research method rather than a quantitative one, and to offer a detailed outline of the actual research approach adopted. A qualitative approach was selected because of the clear advantages of qualitative over quantitative methodology in the CHP research setting. Although quantitative methodology is usually employed in agency settings, it suffers from a number of limitations in this instance. These are conveniently grouped into four categories: context, sample size, goal definition and research implementation. Each will be discussed in turn. After establishing the basis for choice of methodology, we examine the specifics of the research process utilized in this investigation of the CHP team.

Qualitative Evaluation Research

Context

Because the subject of teamwork collaboration has not yet been examined thoroughly, there is no body of theory on which to rely. Any methodology adopted in such circumstances must be necessarily exploratory, and qualitative

methodology most effectively satisfies the need to explore. Quantitative evaluation research would tend to generate statistical results divorced from proper understanding of a program's social context. By uncritically accepting the results of quantitative testing, evaluators often produce studies of low validity. For example, in studying a health care team, an investigator might correlate individual team members' need for achievement with their collaboration in team activities. In doing so, he might discover statistically significant differences but never ask whether factors other than need for achievement might not be more important in determining the course of team cooperation. Because of problems such as this, quantitative research has recently come under heavy attack, with some critics suggesting that quantitative methods be supplemented or supplanted by qualitative research (Popham 1982).

Several social scientists argue in favor of using a specifically qualitative approach to applied research in order to take program context into full consideration. Donald Campbell is perhaps the most prominent proponent of this change in orientation toward qualitative methodology. He states that the present division of labor into qualitative and quantitative "camps" is unhealthy and argues that

case studies will catch unanticipated side effects more structured approaches might miss.[1]

Arguing along the same lines, R.S. Weiss and Martin Rein have produced the most frequently cited alternative to quantitative research evaluation. They refer to their approach as "process-oriented qualitative research" and call for careful description of the "before, during and after" in introducing programatic changes (1972, 1977). Gerald Britan advocates much the same approach, using the term "contextual evaluation" (1978). All agree in noting that exploratory, problem-oriented ethnographies increase the chance of hitting upon variables critical to an understanding of the process of planned change.

In contrast to quantitative research, qualitative investigation seeks not to predict but to understand behavior (Mullen and Iverson 1982). Rather than attempting to establish the existence of predicted correlations between certain factors, for example, a qualitative study of a health care team would examine the broad research setting in a search for the factors of most significance in establishing collaborative team efforts. This has been an important aim of this study.

Restated, qualitative methodology is exploratory. It allows the researcher to shape and reformulate more precisely those questions that need to be asked, prior to asking

them. The information gathered may then be used in building middle-range theories. After such theories have been established, they may, of course, be tested for verification with quantitative methodology.

Sample Size

The second case in which quantitative research is inappropriate occurs when the research population is small enough that it can be easily examined by one researcher. Bennis, for example, supports the qualitative case study as a proper means of program evaluation (1968). He notes that experimental sciences require quantitative research designs because they assume the process they are studying goes on in a "black box." Bennis concludes by remarking that when it is possible to observe throughout the experiment, the need for the experimental model is bypassed. Such is the case in this study of the CHP team. Because the research population is very small (N=12), it is possible to study all team members and to investigate most aspects of team life.

Goal Definition

A third difficulty in using quantitative evaluation research occurs when investigating "broad aim" social programs in which program goals are diffuse and unoperationalized. Because current programs often have goals that are global in nature, attempts to identify and further define

these goals often produce a major stumbling block in carrying out health and social services research.[2] In the case of this study of teamwork, the team goals are defined but diffuse: "delivery of interdisciplinary health care." In order to carry out quantitative research it would be necessary to define the goals more precisely and to operationalize them so that criteria for their achievement could be established (Blalock 1972). In this particular teamwork study, however, such an exercise might bypass consideration of such issues as whether the "team" was even operating according to commonly accepted definitions of teamwork. A quantitative approach is therefore also inappropriate with regard to this aspect of investigation.

Research Implementation

The fourth problem in utilizing quantitative evaluation research revolves around difficulties in administering research in action settings. Because controlled experiments were originally developed for use in laboratory settings, it is often impossible to transfer them intact to agency settings where research conditions cannot be easily controlled. There are, for example, often planning or programmatic constraints. Many program administrators refuse to allow random assignment to social programs because they do not want to withhold treatment from anyone. This classic design also demands that the program remain constant over time and many

program directors are unwilling to have their flexibility restricted in this manner.

As a result, quasi-experimental or non-experimental research designs must often be used and these sometimes have severe methodological problems of internal validity (the ability of the research design to yield an unbiased estimate of the effect of treatment) and external validity (the extent to which the research findings are generalizable to the population which the policy will affect). Evaluators often try to overcome these methodological weaknesses by using a "patched-up design" in an attempt to rule out all sources of error (Weiss 1972).

In this particular study of teamwork, the shift in the overall program presented the fourth barrier to quantitative research. The team was not a static entity. Instead, members' responsibilities were fluid and varied as a consequence of the program development efforts in which the team constantly engaged. This aspect of the team's nature presented a final reason for selecting qualitative over quantitative methodology.

An Overview of the Fieldwork Situation and Data Generation on the CHP Team

The foregoing section argues for qualitative research as a more appropriate method for studying this particular interdisciplinary/interprofessional health care team. Participant observation was the specific approach adopted,

supplemented by open-ended interviewing as the research focus narrowed. Michael Agar's description of the research process as a narrowing "funnel" provides a useful means of describing the course of analysis of the CHP team (1980). At the beginning of the research, I adopted a broad outlook by examining every aspect of team life. As my research continued and I gathered new materials, I developed hypotheses. After gathering yet more data, these hypotheses were either reworked and retained, or discarded. This process continued until the field of research narrowed to a select few propositions about teamwork which then became the focus of research activities. At this point, the hypotheses I developed in earlier stages of research were tested in depth. The funnel analogy, then, is appropriate: a beginning wide-open approach was gradually replaced by concentrated examination of those factors withstanding initial hypothesis testing. In this manner, my hypotheses were allowed to grow from detailed understanding of the field research situation.[3]

In the first and broadest stage of my research, I investigated many aspects of CHP team life. Being concerned with establishing myself as a researcher and member of the CHP team, I sought orientation by gathering information about the team's history and present situation. To this end, and throughout all my research, I examined behavior

(what people did--real behavior), speech (what people said should be done--ideal behavior), and the products of behavior (what people had--archival material).[4]

In seeking to orient myself specifically to team operations, I observed the activities of all team members. For example, I attended all program meetings, went on trips with the team to screening clinics located in other towns, and watched x-ray procedures, a heart catheterization and heart surgery. I was informally introduced to all program personnel as well as to personnel from other clinics who were working in cooperation with CHP staff. More formal introductions were arranged with the administrative and clinical directors of the hospital, the chairman of the hospital board of directors, the director of nursing, the chief of residents, the hospital biostatistician and the previous CHP team anthropologist. In these formal meetings discussion centered on the history and current position of the CHP within the hospital.

By the second stage in my investigation, I was operating with a general understanding of the team's history and functioning, and I began to narrow the funnel of my research activities. I was not concerned with the formation of initial hypotheses. By this point, I was becoming aware of the existence of separate subcultures within the team: one formed by the medical personnel, the other by the social

science staff members. I was also beginning to sense the overarching dominance of medical values within the team. Feeling that the existence of either medical dominance or subcultures might have a decisive impact on team collaboration, I began an attempt to document the influence of these factors. At the same time, I searched for other factors, such as personality and ethnicity, which might be of equal or greater importance to team operations. In a sense, my discovery of the "life and times" of the two program subcultures provided a creative tension spurring me on to seek a deeper understanding of team dynamics.

In my position as team anthropologist I was now operating as both participant and observer. I had total access to all team data, such as program records and statistics, in this small group setting. Because the population was finite and small (N=12), there was no need for sampling. I was able to observe and record much that occurred around me in the daily process of team life.

I attended all team meetings and functions in the company of my pencil and pad, which I put to use in taking notes.[5] I took notes openly in formal meetings and informal discussions. If, however, conversations were confidential or controversial, and I felt that open note taking might hamper free discussion, I would reconstruct the conversation

at a later time. All of my notes, both on-the-spot and reconstructed, were typed into my daily fieldnotes.[6]

Throughout my gathering of information and note taking, I watched for patterns of behavior to emerge. In the process, I constructed records for myself, such as seating and activity charts. For example, I recorded the travel of all team members on a monthly chart, in order to establish a rough index of the amount of program time devoted to funding. During this phase, I also collected program documents such as grant proposals and statistics on the number of patients seen. I was especially careful to collect all written material in which the program described itself, for either granting or public relations purposes.

Another part of my research was carried out in classes which the sociologist and I taught to program and hospital medical personnel. These hour-long classes, thirty-five in all, were organized as semi-structured lecture/discussions of various aspects of the relationship between social science and medicine. They were taped.

Yet another opportunity for discussing problems of team collaboration arose when the team embarked on a series of team development sessions designed to improve team operations.[7] By this time team members had become aware of problems of collaboration, possibly as a result of my focusing on this as a topic of research and certainly because

of difficulties experienced in incorporating the sociologist and anthropologist as new team members. These seven two-hour sessions covered concrete aspects of teamwork, such as program goals, staff roles and coordination and negotiation between team members. They were also taped and transcribed.

The third and final stage of my study consisted of applying the various analytic concepts developed during the second phase of my research in order to see what sense they made of the data I had collected. Narrowing my research project to a concentrated investigation of those factors I had determined to be most important to team collaboration, I constructed and administered a semi-structured interview schedule (see Appendix A). This schedule was designed to investigate each team member's perception of possible factors affecting team collaboration which I had pinpointed in the previous stage of research. Here, as in all my research, I did not interview only key informants. I interviewed everyone, both from within and from without the program, who seemed connected to or concerned with program operations. This activity yielded forty hours of taped interviews.

After gathering the information from my interview schedule, I checked its reliability by asking for evaluations of team functioning by outsiders called in as temporary consultants to the team.[8] For example, the team had

hired a documentarian-photographer to produce a slide-tape presentation on the program's team functioning. He also interviewed all team members on problems associated with team functioning shortly after I completed my interviews, and he cooperated in giving me a copy of his tapes. His comments and interviews were a valuable aid in checking the validity and reliability of the information I had gathered. I was also able to check the validity of my analysis by observing the hiring and induction of a new anthropologist health team member.[9] I continued to have informal discussions with various team members concerning problems of teamwork throughout all phases of my research.

Summary

Qualitative research was selected as the most appropriate methodology for this investigation because of four contraindications to a quantitative approach. Restated, they are: (1) little is known about the dynamics or context of teamwork; (2) the sample size (N=12) was small enough to allow thorough investigation of all research subjects; (3) the program goal was too broad and diffuse to research easily; and, finally, (4) it is difficult if not impossible to implement quantitative research in action settings.

To conclude, a quantitative methodology would not have generated either the necessary or sufficient information to obtain adequate results. Hence, a qualitative methodology,

organized in the form of an ever-narrowing funnel, did provide an effective approach to studying the CHP team. Because team operations had not yet been fully subjected to social science inquiry, it was first necessary to carefully examine the dynamics of this particular health care team. Qualitative methodology provided a strong tool for assessing day-to-day team operations and thus for defining influential factors. The factors which were pinpointed during the course of the research as having the most impact on team collaboration will be discussed in detail in the following chapters of analysis.

Notes

1. Campbell (1978) still believes quantitative data can go beyond qualitative in subtlety, but also states that if these two sources of data are ever in conflict the program evaluator should throw out the quantitative data.

2. Ambiguous and conflicting goals can cause a program to fail even before it has begun. In their evaluation of a Skid-Row Alcoholism Program, Lincoln Fry and Jon Miller (1977) discovered that because staff members were unable to specify an agreed-upon goal they were unable to implement program objectives.

3. Barney Glaser and Anselm Strauss (1967) discuss detailed strategies which may be used in generating theory from qualitative data. Their particular approach, called "grounded social research," is utilized in this study of team collaboration. In this kind of inductive research, both the research situation and methodology are dependent. In other works, the data collection and analysis are done concurrently.

4. This description of the focus of my research is taken from Pertti Pelto (1970). The collection of papers edited by Raoul Naroll and Donald Cohen (1973) is another

useful source of general information on method. Hortense Powdermaker (1966), Myron Glazer (1972) and Michael Agar (1980) have all written excellent books covering the process of qualitative research. John Brimm and David Spain (1974) discuss the use of quantitative research in anthropology. In the past, anthropological method has often gone unexamined. The books listed above indicate a change in orientation. Fieldwork, always a rite of passage for anthropologists, is now being closely examined as a data gathering technique.

5. Staff members became accustomed to my constant note taking. A team member once remarked: "Linda, you're always there, you and your notepad."

6. In gathering the data for this study, I produced roughly 180 pages of single-spaced typed fieldnotes.

7. This program was developed by Irwin Rubin, Mark Plovnick and Ronald Fry of the Massachusetts Institute of Technology. Entitled "Improving the Coordination of Care: A Program for Health Team Development," the authors described their training booklet as

> a program of task-oriented activities aimed at helping any group of health workers and/or administrators responsible for the delivery of health care to get its job done in the most effective way possible. This program focuses on specifically defining the job that needs to get done and procedures for doing it. (Rubin, Plovnick and Fry 1975:4)

8. At various points during my tenure with the CHP I spoke in depth about program operations with four outsiders who had contact with the CHP. These were individuals hired by the CP to do consulting work or to produce some service for the program.

9. This anthropologist, the third to be hired by the CHP, was selected at the beginning of my second year with the program when I was working as a consultant to the team. At that time I was living in Mexico City and commuting to South City for several days each month. I was the person in charge of coordinating the search and hiring procedures for the anthropologist, who was expected to take my place as a full time team member.

CHAPTER IV
TEAM SUBCULTURES AND MEDICAL DOMINANCE IN THE CHP TEAM

The purpose of this chapter is to delineate, with examples, the operation of one particular interdisciplinary/interprofessional team, the CHP team. The particular aim of this ethnographic effort is to demonstrate the vital need to understand the internal dynamics of team behavior. As discussed earlier, an anthropological approach focusing on culture was deemed an effective method for analyzing the workings of an interdisciplinary/interprofessional health care team. Although teamwork has received increasing investigative emphasis in recent years, substantive research on team operations has been neglected. Despite this research gap, the supposed advantages of teamwork have been promoted in countless descriptive articles and health care teams have become a kind of fad. Most health care teams have been put into operation without careful assessment of their value and goals.

In light of this, the application of the anthropological concept of culture has two advantages: first, it focuses attention on the presence of two separate subcultures, the medical and the social science; and, second, it provides

a technique for analyzing the relationship between the two subcultures, and therefore of explaining team operations. The key to understanding that relationship is the overwhelming dominance over the "minority" social science subculture by the "majority" medical subculture.

In recent years, small group research has received concentrated attention, and on first approach seems to provide a useful means of understanding team process. This appears not to be the case, however, since teams differ in significant ways from voluntary small groups. Small groups based on voluntary association tend to run on the basis of consensus. In contrast, teams often find that members, leaders and roles are assigned by the larger organizational or bureaucratic system of which the team is a part (Golin and Ducanis 1981). As a result of this forced association, teams are usually formed of individuals from many different educational and work backgrounds, or "cultures." A subcultural approach is necessary, then, because interdisciplinary/interprofessional teams are not simply small groups.

Team members from dissimilar backgrounds have difficulty understanding both the methodology and the area of expertise of those from professions or disciplines other than their own. Forced into a working association as part of a team, team members may find themselves forming into any number of coalitions or subcultures within the team.

Interdisciplinary/interprofessional teams are composed of, at a minimum, two or more subcultures: one formed of researchers, the other of practitioners.

My discussion of the majority/minority subculture realities of CHP teamwork relies on the careful interweaving of extant pertinent social science reports with my own extensive fieldwork-based observations. The existence of differing goals and values within teams results in the oft-noted problems of team conflict. Within the CHP team, I am calling these goals and values subcultures. In a setting of differing subcultures, team conflict is inevitable and team discord the predictable result.

In utilizing the concept of subcultures to explain team conflict, there is an additional factor which must be considered--status. One subculture may dominate another if its members possess higher status by virtue of their membership in a certain profession or discipline. Status differentials have a powerful impact on the negotiations which occur between team subcultures, particularly with regard to the role which the members of each will be allowed to play in team operations. Within the CHP team, the two subcultures were ordered by medical dominance. As a result, members of the social science subculture found themselves required to interpret and adapt to medical demands.

Medical and Social Science Subcultures in the CHP Team

Although dissension in health care teams has been thoroughly documented in team literature, to date no social science researcher has explicitly used the concept of culture to produce a theory which adequately explains team conflict. Both C.P. Snow (1961) and George Foster (1962, 1969) have discussed the existence of professional and disciplinary subcultures in the modern work-a-day world. Neither of the authors, however, has applied his ideas to the common problem of conflict in health and human service teams.

In the following analysis and interpretation of the field data and pertinent literature, the term culture refers to "learned and transmitted motor reactions, habits, techniques, ideas and values" (Kroeber 1948:8). In other words, culture constitutes a set of "rules" for the behavior of its members. Subcultures are subgroupings which have differing goals and values. They have their own rules for living, with reference to behavior and attitude, which differ from those of the larger culture as well as from those of other subgroups.[1] In the case of the CHP, all team members are Americans. Specifically, the team studied formed two subcultures of this larger culture, rather than the single, health/work-oriented subculture one might expect.

The most jarring discovery of this field investigation was my realization of the extent to which the CHP team actually functioned as two teams. Although the team presented itself to outsiders as a cohesive unit, close examination revealed that there were really two separate yet cohesive teams, each of which formed a subculture of the larger CHP team, or overall team-culture. One subculture, indeed the "majority subculture," was composed of members of the health professions; the other, or "minority subculture," of personnel from the social science disciplines.[2]

Members of the medically oriented subculture included the physician-director of the program, a pediatric cardiologist; four Mexican American nurse practitioners, certified as both nurse practitioners and "pediatric cardiology associates;" a social worker; a technician-administrator, also chief of the EKG-EEG staff at City Hospital; a secretary-coordinator; and a public relations consultant. The social science group included an anthropologist (LCI), a sociologist and an economist (see Table 4-1).[3] The social worker is included as a member of the medical subculture because social workers have been traditional members of practicing "core" medical teams while individuals from other social science disciplines, with the exception of clinical psychology, have not. The CHP team social worker was a practitioner and thus similar in behavior and attitude to other

medically oriented staff. In contrast, members of the social science team were researchers.[4]

TABLE 4-1
Division of the CHP Team into Subcultures

CHP Team	
Medical subculture	Social Science subculture
physician-director 4 nurse practitioners social worker technician-administrator secretary-coordinator public relations consultant (part-time)	anthropologist sociologist economist (part-time)

This division into subcultures was informally acknowledged by all team members. For example, during an early team meeting in which problems of teamwork were being discussed, a medical team member pointed out the pattern of subgrouping:

> You three [social scientists] communicate with each other. You talk, go to lunch and socialize as a group. On the other hand, the rest of us always stick together.

In daily terms of reference, all medical team members, including the social worker, referred to the anthropologist and sociologist (the two full-time social scientists) as the

"social science team." Further discussion of this clustering pinpointed the division between the social science and medical subcultures as being based on work activity. A second medical team member noted: "The rest of us are tied together very closely. We work together as a team and we do have more communication."

Yet another team member then remarked that the lack of communication between social science and medical personnel was aggravated by the fact that the sociologist and anthropologist were sharing an office separated from other members of the team. The economist also spent a lot of his time in this office during his weekly consulting trips. The team decided to rearrange its office space as a result of this discussion. The anthropologist and sociologist moved into an office area which they shared with the secretary-coordinator, thus putting themselves at the hub of team activities. This move helped alleviate but did not solve problems of team collaboration.[5]

Although team members acknowledged these groupings, they were not fully conscious of their significance with regard to team collaboration. Closer examination of subcultures, however, yields striking differences in behavior and attitudes, which will be fully examined in Chapter VI. It was as though there were two teams rather than one. Members

of each subculture were in daily close association, as they worked, talked and ate together.

The distinction between medical and social science subcultures reflects the separation between academic social science disciplines and medical professions. The social scientists were all members of social science disciplines (economics, sociology and anthropology) in which the goal of research received high emphasis. On the other hand, the medical personnel had all received professional training stressing practical aspects of providing medical and psychological therapy to patients. In medically oriented professions, practitioners receive training and are then certified (by an R.N., M.S.W., or M.D. degree) as being capable of performing certain technical, medical or psychological procedures. In contrast, students in disciplines study a disciplinary area of thought and are then certified (by an M.A., M.S., or Ph.D. degree) as being capable of performing research in that discipline.

This separation between medical professions and social science disciplines was made clear by the comments of one of the nurse practitioners who pointed out that the social science team members were connected by "academia stature [sic]." He observed, not uncritically: "You are all working--supposedly--on your Ph.D.s, so you all have similar interests."

Medical Dominance in the Health Services

A brief examination of medical dominance in health service organizations illuminates the workings of the CHP team. Two subcultures within one team might co-exist peacefully if they sought common goals. When one subculture dominates the other, however, collaborative relationships tend to be inhibited. Use of the theme of medical dominance in research is not new. Medical dominance in general, and physician dominance in particular, have been topics of extensive theoretical research by the sociologist Eliot Friedson (1970a, 1970b). It has become such a familiar subject that it is mentioned in nearly every article treating health care teams. Within the CHP team, medical dominance functioned to create a situation in which the social scientists, as members of a separate subculture, were isolated and felt unappreciated.

Physician and Medical Dominance in the CHP Team

Like other teams described in the review of the literature in Chapter I, the CHP team was subject to medical dominance. Medical, or clinical dominance[6] determined nearly every aspect of the structure and operation of the team. The CHP team, moreover, was particularly subject to domination by the physician. Dr. X's dominant role was revealed in a number of ways. It was he, for example, who held the formal title of "project director" and he was introduced in

this manner as the senior member of the team. The team itself was known within the hospital and in the local community as "Dr. X's health team."

The dominance of the physician was most clearly reflected in the amount of attention he received from all staff members, particularly those from the clinical component of the team. The question of concern to most team members in accomplishing their goals was: "What kind of mood is he [the doctor] in today?" This issue was often raised in discussions which team members held among themselves: "Are we [meaning "is he"] really in the mood? I would hate to pick the wrong mood." The following exchange provides another example of this focus:

> "Ta-Da! He's here!"
> "Who, God? Jesus Christ Superstar?"
> "I didn't say God. I said 'He's here.'"
> "Well it's 'He' with a capital H, isn't it? Who is that but . . ."

Medical staff members were very aware of and concerned with the doctor's actions and opinions. For example, whenever the social worker was approached with new ideas for program projects his response was usually: "I wonder what Dr. X would think about that?" Another example of respect accorded the physician's wishes occurred when the anthropologist received what she suspected was an inappropriate counseling referral. The physician had referred the father of a 14 year old mongoloid patient on the grounds that he

was showing "excessive affection" toward his son, by holding him on his lap and hugging and kissing him in the examining room. The anthropologist talked this case over with the nurse practitioners, suggesting that emotional demonstrativeness might vary from family to family, and ascertaining that this "problem" had no readily apparent bearing on the child's health. The anthropologist then stated that she was going to talk to the physician about the inappropriateness of this referral. "No," said the nurse practitioners, "If the chief says do it, do it." The anthropologist complied.

The following example further documents the pervasiveness of the medical dominance over team activity. On one occasion, a nurse practitioner explained why staff had to "hustle" when Dr. X called them on the phone: "When the chief calls and asks a question, he wants to know the answer now. He doesn't want to know that we don't know either." These responses to the medical team's perception of the power situation underlay the remarks of another medical team member who stated flatly: "People don't disagree with Dr. X."

Dr. X did not actively seek deference from team members. As one of the social scientists pointed out, he was very "horizontal" in his work orientation. It was the physician's desire to include all team members in team projects so that they might all "develop and reach their

full potential." In following this principle, he gave the team secretary responsibilities as "coordinator" and, in a hospital meeting of the paraprofessional committee, asked why the janitor was not being included in a discussion of hospital morale.

Dr. X sought the opinion of others and listened respectfully. He observed, for example, that he admired the anthropologist "for not being afraid to state her opinion and, having stated it, to stick to it." His reflection suggests that such an occurrence was unusual enough to be cause for comment. Although social science team members were not afraid to approach the physician, medical team members were more timid. Even if Dr. X did not seek automatic deference from the medical team, he was accorded it.

Although the physician did not desire absolute deference, he was cognizant of his elevated status within the team. He was, for example, very aware that team members were not, as he once mentioned during a team meeting, his "real peers." He seemed to imply by this statement that only other M.D.s were his true equals.[7] Occasionally he would mention his educational background during team discussions by way of explaining why the team should do as he wished: "I'm 16 years past high school in college and medical school and medical education."

Dr. X may not have actively sought dominance, but he did maintain dominance by allowing the program to remain structured as it was. An example of this appears in the terms of reference with which he allowed himself to be addressed. The physician was the only team member to be referred to by title--"Dr. X"-- rather than by his first name. Even his wife, in interactions with other team members, usually referred to him as Dr. X. The nurse practitioners commonly called him "the chief" and occasionally referred to him in his absence as "Dad."[8] One of them explained Dr. X's position as "chief" of the team to an outsider: "He's the main man, the one at the very top."

Yet another example of the manner in which physician and thus clinical dominance pervaded the program can be seen in the way in which the two male South City-based nurse practitioners modeled themselves after the physician, to the point that one of them even imitated some of his personal mannerisms. It was the subject of some amusement among the social science team to occasionally see this nurse practitioner stalking down the hospital hall like a miniature Dr. X, with his shoulders hunched and his head down in exactly the same body posture the physician adopted when worried or upset.

Aside from these personal mannerisms, the nurse practitioners assumed physician-like behavior in relating to other

nurses, thus acting in a manner usually reserved or allowed only to physicians. The implication of such conduct was not lost on hospital and outreach clinic nurses who felt the nurse practitioner's modeling of the physician's role to be an attempt at status aggrandizement. Their resentment can be seen in a statement in which a hospital nurse described the nurse practitioners as: "The ones flitting around the halls, carrying a stethescope and pretending to be doctors" and again in an outpatient clinic nurse's sarcastic comment that the nurse practitioners were "Oh, so professional!"

A final measure of physician dominance can be taken in the manner in which team activities revolved around the doctor's presence. The morning patient management meetings, for example, did not start at a regularly scheduled time. Instead, all staff members waited patiently around the general time in which the meetings occurred until the physician appeared. Because of uncertainty about the time of his appearance each day, staff members would pay close attention to the physician's presence in the hospital and to the activities in which he was engaged in order to estimate the time of his arrival at the meeting table. Similarly, during team screening trips to the Basin the physician decided when and where to stop for food, when to return again to work and when to leave for home. During these events, team members

would patiently wait until the physician was ready to begin or end a certain activity.

In addition to the domination of the physician, the entire program could be described as being dominated by medical, as opposed to social science, concerns. It should be noted that medical team members dominated numerically. There were nine medically oriented members of the team, but only three social scientists. If part-time staff members are not counted, the numbers are eight to two, a ratio of four to one.

Given the fact that the CHP team delivered medical care in a medical hospital and clinic setting, medical dominance might not seem surprising. This was a team, however, which represented the social science "contingent" of its program to granting and other outside agencies and individuals as being a primary part of its innovative approach to the efficient delivery of comprehensive, holistic health care. Consequently, the social science segment of the team did not expect to discover that behavioral problems would be relegated to a place of such secondary importance. The physician's response to the anthropologist's questioning the medical emphasis of the CHP demonstrates the medical assumption of superiority:

> I am a cardiologist. I'm not a social worker, I'm not an economist, I'm not an anthropologist and if I left the program would fall apart unless you got another cardiologist. I'm still a

> cardiologist, and if I am the project director then that does take precedence. If the anthropologist wants to become project director and make it an anthropological team and hire me, if I'm willing to take the job, then fine. I am a cardiologist and that is what we have to be doing, so behavioral problems do take somewhat of a secondary role.

A social science team member expressed basically the same perception of team organization as Dr. X, but in a somewhat more critical tone:

> The team is built around the skills of a single individual. The mission of this team is to utilize these skills as broadly as possible. It's the physician who has absolute power and control by virtue of the fact that his skills are indispensible and yet it's precisely this person whose training is so narrow and who's at a disadvantage in trying to be a generalist and to preside over everything.

The nurse practitioners also saw medical concerns as being predominant. Specifically, they saw their own medical role as primary:

> I see the nurse practitioner as being the main focus of this team. Bringing in social scientists is fine but the most important thing we do here is provide excellent service for less money by utilizing Mexican nurses. With the nurse practitioner's training, I see them as the main concept and there is no limit.

This attitude is demonstrated also by the nurse practitioner's statement that "we [the nurse practitioners] are the program" and is reflected in the organizational chart which the nurse practitioner quoted above drew to explain himself (see Figure 1).

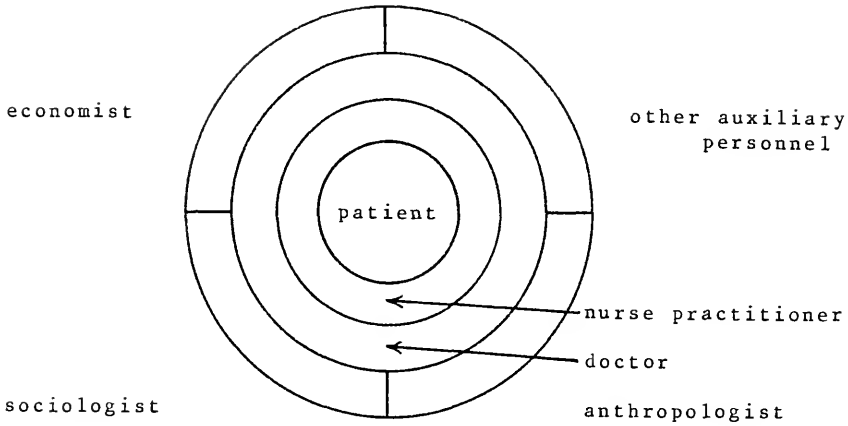

FIGURE 1
A Nurse Practitioner's View of the CHP Team

This diagram clearly demonstrates this nurse practitioner's valuation of "direct contact," or clinical care. By classifying patient, doctor, and nurse practitioner as integral participants in the therapeutic process, he relegates the program social scientists to an "auxiliary" or ancillary position.[9] He does not perceive, and so does not include, the relevance of the indirect process and instruction-related core which the social scientists might potentially provide.

In concluding this discussion of physician and medical dominance in the CHP team, it is important to note that medical dominance precludes social science equality. For, in defining medical care as "primary" and separate from social care, medical personnel automatically relegate social

science to a position of less importance. The operation and ramifications of this process will be further discussed in the next chapter. Before doing so, however, we will discuss the unwillingness of the medical subculture to publicly admit the existence of medical dominance within the CHP team.

The "Real" and the "Ideal" Program

Although medical members of the team proudly described the CHP program as egalitarian, the overwhelming power of the physician belied the accuracy of their views. Physician and medical ascendancy have been thoroughly documented in the previous section. In the face of daily evidence to the contrary, however, the ideology of equality among team members received constant emphasis.

This contradiction between ideology and reality resulted in some confusion. As physician-director of the program, the doctor was indeed the team's most powerful member, the only one to "oversee everything." This fact was clearly recognized, although not publicly admitted, by all team members. For example, the following "ideal"[10] statement about program operations was made by a medical team member during a public interview:

> The physician is the director, but I don't think he acts like he's the boss. I don't even like the word boss; actually I don't think we have a boss.

The same individual made this assessment of "real" program affairs during a more private moment: "We say that this is a democratic organization, but we know damned well it isn't." A member of the social science component of the team analyzed the situation in more detail:

> The program really operates as a participatory autocracy. The locus of decision making is squarely in the hands of the physician. But even though he makes the final decisions, he does solicit a great deal of input from other team members.

A member of the medical team described the decision-making process similarly:

> The team is very democratic. Everybody always gets to put their two cents into the discussion. Dr. X, however, is a man of conviction, the type of guy who can certainly make a decision. When push comes to shove he definitely takes the bull by the horns, but he never moves without the input of the rest of the team.

Differences in vocabulary and language are apparent in these two quotes and illustrate the kind of subcultural distinctions which will be further detailed in Chapter VI.

In the CHP team's public presentation of itself as an egalitarian, interdisciplinary program the chart presented in Figure 2 might have been constructed to explain team workings to outsiders.

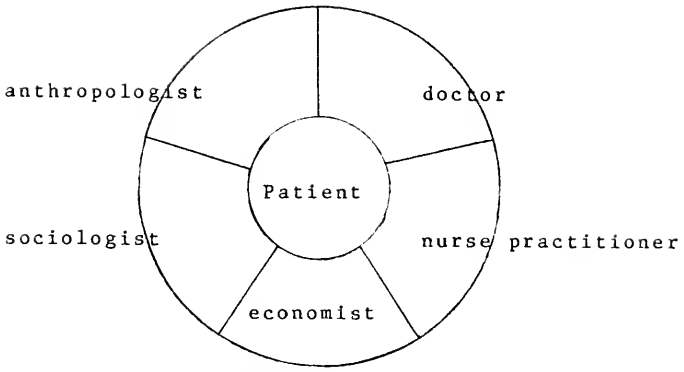

FIGURE 2
A "PR" View of the CHP Team

This chart is dissimilar to the nurse practitioner chart of the team presented in the previous section (see Figure 1). It also contrasts markedly with the chart devised by a social science team member on the basis of several months observation with the team (see Figure 3).

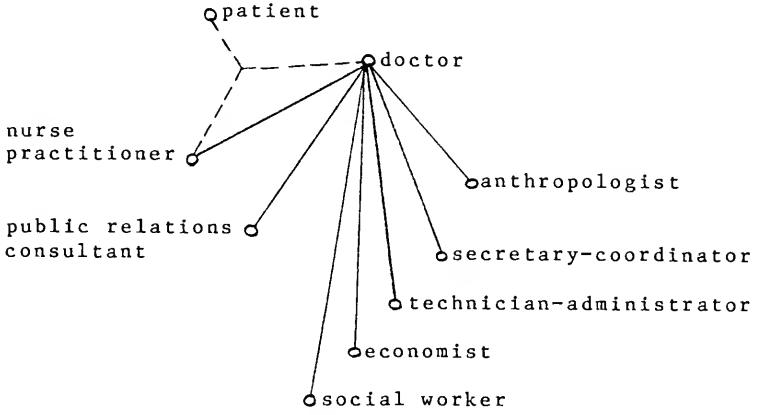

FIGURE 3
The Sociologist's View of the CHP Team

The idealization of program operations portrayed in Figure 2 chart caused some difficulties in adjustment for newcomer social science team members. During their early days with the program, the social scientists behaved inappropriately by acting on the basis of the program's public statements. It did not appear to medical staff, then, that the social scientists were making any attempt at all to "fit in" with actual program operations.

Medical personnel developed this impression of the social scientists as "not trying" because the social scientists were operating under erroneous assumptions. The anthropologist's and sociologist's primary supposition in entering the team was that they had been hired to work with a health care team familiar with the capabilities of applied social scientists. They were wrong. The social scientists erred again in assuming, additionally, that statements made by team members regarding the role of the social scientists and the nature of team operations could be taken at face value.

During their first six weeks as team members, the sociologist and anthropologist became aware of actual conditions within the team. They began to note, for example, that some team members were "more equal than others."[11] Because the team's rhetoric produced a set of ideal statements which conflicted with reality, the expectations of the

social scientists were raised and then dashed. They responded with frustration, disappointment and anger.

Whereas medical team members could only occasionally be heard to complain about having to "wait on" Dr. X, the social scientists were more vociferous. While medical team members made infrequent remarks such as: "That man can spend two hours on each patient. If we really wanted to we could follow a schedule and leave here at a certain time," for the most part, they waited without complaint. The social scientists were not as accepting of this situation and felt very irritated at having to "bow" to the idiosyncratic time-table of one individual. These angry feelings are clearly evident in the comment of a social scientist who referred to the medical team as Dr. X's "hacienda staff," going on to state that the physician was operating in the patron ("boss-man") or Mount Olympus ("the god speaks from on high") model. Other social science comments also demonstrated annoyance and resentment:

> "For Dr. X it's 'all of you are equal, but not me;'"
>
> "Dr. X doesn't forget for a moment his prerogatives as leader;" and
>
> "Dr. X is a guy who plays when he feels like playing and plays by his own rules."

The social scientists thus experienced numerous difficulties as they attempted to join the team as new members. Many of their problems in adjustment can be traced to the

dissonance between the program's ideal public statements and the reality of program operations.

For example, in being hired as team members, both the anthropologist and sociologist were told that, in addition to teaching social science to hospital residents and managing minor administrative and counseling responsibilities, they would be given the opportunity to complete a major research project which might then form the basis of their dissertation work. This information was given them by the outgoing social scientist, the first team anthropologist, who also added that although the research was to focus on some aspect of health care delivery in the Southwest, it need not be directly related to the concerns of the CHP. The social scientists eventually were to learn, however, that although they were hired as researchers, this was not the role they were actually expected to fill.

During their initial weeks with the CHP, the anthropologist and sociologist were unable to gain a clearer understanding of other team members' expectations of the social science role. Whenever they queried "What would you like us to do?" the response was always, "No, no, you're the social scientists. You tell us what you're going to do." Through these early days, the social scientists participated primarily in the role of researcher/planner. This was the

kind of work they wanted to do and the kind of role they believed other team members desired them to fill.

Throughout the early months of team functioning with a full complement of clinical and social science positions, the occupants of the latter were aware that they were not being accepted by medical team members. This perception was traceable largely to the behavior of other team members, most of whom chose to relate to the social scientists in a somewhat frosty and aloof manner, as discussed in Chapter II. It was not until the social scientists had been with the program for nearly one and one-half months, that they first received verbal proof of what, until that point, they had merely suspected. The social scientists found that medical team members were not satisfied with their contribution to the program and that the fault in this "problem" was seen to lie squarely with the social scientists who were not attempting to "fit into" program operations.

It was during the first team meeting for program development that the physician began to speak with some anger (his remarks were addressed specifically to the anthropologist, but were also intended generally for the sociologist):

> I think you are a bad anthropologist. I hate to say it but I do. Why can't you get along with the other members of the team? You're a social scientist, and yet you can't gain acceptance by the natives of this program.

Stunned, the social scientists asked what he did expect of them.[12] The physician then requested development of a system for interface and coordination between the psychological and medical care provided by the program:

> Behavioral problems are second in importance only to cardiac care. We need to develop a system for record keeping and referral--for the proper care of behavioral problems.

Shortly thereafter the physician also requested that they teach a social science counseling course to the nurse practitioners. As the sociologist and anthropologist received the physician's requests, they began the first of their negotiations with regard to the role they would be allowed to play within the program.

In responding to the physician's requests,[13] both social scientists began to question other team members more closely to discover if they too had hidden role expectations. The sociologist and anthropologist discovered, to their complete surprise, that the social worker had been told by the previous anthropologist that they were to be members of his staff and that he counted upon them to carry out his orders and to assist him in providing emotional and social care to program patients. The nurse practitioners had other wishes. They expected the social scientist's activities to revolve around them:

> We're the program, we're the nurse practitioners. You're supposed to be studying us. So why didn't you come to talk to us? When you came we didn't

> accept you because you didn't come to find out what the nurse practitioners were doing and that was your job, wasn't it?

Finally, the public relations consultant believed the social scientists would be doing much the same work as the social worker, in addition to publishing articles on the team's activities:

> Won't you be providing services by going down to the Basin and doing consultations like the social worker? And have you considered doing any publishing?

During the course of these inquiries, the job description for the "Behavioral Scientist" was uncovered:

> The incumbent is responsible for coordinating the writing of a doctoral dissertation with an analysis and documentation of the model approach to health care delivery exemplified by the CHP team. This individual--in cooperation with the Hospital Director of Medical Education and the CHP Social Worker--participates in the educational program for resident level physicians. The Behavioral Scientist also aids the Social Worker in patient management and general problem solving.

This description was certainly at variance with prevailing perceptions within the program, but was more "liveable" for the social scientists. Although other team members were aware of this description, they did not take it seriously. It was viewed as a document produced solely to satisfy hospital administrative requirements.

Summary

The foregoing commentary on the operation of the CHP team reveals the advantages of adopting an anthropological

approach to analysis of such interdisciplinary/interprofessional teams. In highlighting the existence of two separate subcultures and in assessing the unequal relationship between the two, the analysis helps to explain the basis for the conflict within health care teams so often commented upon in team literature.

The CHP team was seen to operate as two subcultures which formed on the basis of professional socialization and subsequent professional practice. One subculture consisted of members of the medically oriented professions, the other of personnel from the social science disciplines. Members of the medical subculture in the CHP team provided clinical services in the form of psychological or medical therapy. The social scientists, on the other hand, were trained and prepared to act as researchers rather than as clinical practitioners.

Having provided a description of this split within the team, we are able to see more clearly the value of examining clinical dominance as the key to comprehending the relationship between the two team subcultures. Because the members of the "majority" medical culture were dominant, the social scientists were required to adapt to medical expectations concerning their role with the CHP team. It is to this "secondary," or "subsidiary" position, of social science within the CHP team that we turn in the next chapter.

Notes

1. We create categories such as cultures and subcultures in order to analyze social life. In naming phenomena we do not breathe life into them; instead, we merely attach labels to events and facts already in existence in order to permit orderly description of behavior. In this manner, the naming or labeling of things provides a means of adding order, understandability and predictability to behavior.

2. This separation between the medical professions and the social science disciplines is the pattern of subcultural membership which emerged in this particular team. In other teamwork settings subcultural patterns might reveal, as is often reported, a division between nurse and physician or between any other combination of team members. June Huntington, for example, reports on "inter-occupational differences" between social workers and general practitioners doing collaborative work (1981).

3. All team members except the public relations consultant and the economist were full-time staff members.

4. The CHP team social worker held a specialization in administrative social work. This factor enabled him to function comfortably as a member of the medical subculture, although he occasionally seemed to display some discomfort in this association. In the case of the CHP team, however, with its combination of practicing and researching personnel, he fell much more neatly into the camp of the medical team than into that of the social sciences. The same was true of the public relations consultant. Consequently, although the training of both the social worker and the public relations consultant was not specifically medical, their attitudes and behaviors were congruent with those of the medical team. These patterns will be discussed in further detail in Chapter VI.

5. This move by the anthropologist and sociologist into a central office location alleviated problems of accessibility but aggravated problems of research productivity by placing the social scientists in a noisy, distracting work environment. The sociologist and anthropologist responded by closing off their individual desk areas with curtains, thus initiating "La Batalla de las Cortinas" (The Battle of the Curtains), as this skirmish was later dubbed by a witty staff member. The technician-administrator told the sociologist to remove the curtains as

he was in the act of installing them. He refused. She then complained to the physician who subsequently told the sociologist to remove the curtains, a request with which he complied.

6. The term "clinical dominance" seems more appropriate to this discussion of the CHP team. What distinguished members of the medical subculture from social science team members was the clinical, or hands-on nature of their work. I will, therefore, use the terms clinical and medical dominance interchangeably, intending that references to clinical dominance refer more specifically to the singular situation of the CHP team.

7. When the anthropologist directly questioned the physician as to whether this were true, he responded by speaking abstractly of the need for everyone to respect everyone else's opinion.

8. They also referred to the technician-administrator, an older female, as "Mom."

9. Bess Dana notes the common usage of the words "ancillary or paraprofessional to designate the status of social work in the lexicon of health care manpower" (1983:196). She interprets this as further evidence of medical dominance.

10. Charles Wagley discussed the existence of "ideal" as opposed to "real" cultural patterns (1968).

11. This remark was made as a reference to George Orwell's Animal Farm (1946).

12. The physician's statement provided the social scientists with confirmation that other team members perceived the same difficulties in team operation. More importantly, the social scientists realized for the first time that they were being held responsible for this situation.

13. In addition to developing a referral and record-keeping system for patients requiring psychological care, the sociologist and anthropologist began work on separate projects of research. The anthropologist began an evaluation of a health/education program developed in another city by a physician who also worked as a consultant to the CHP team. The sociologist and economist conducted a survey of the attitude of state physicians toward physician assistants.

CHAPTER V
THE "SECONDARY" STATUS OF SOCIAL SCIENCE IN THE CHP TEAM

The operation of medical dominance within the CHP was described and documented in the preceding chapter. This chapter will treat the resulting subsidiary status of social science. When members of one subculture are dominant, the ideas of the minority subculture are less highly valued. It is important to keep in mind, particularly in this section where many seemingly "personal" opinions are being discussed, that members of each subculture responded to those of the other more as "foreigners" than as individuals.

Negative attitudes toward social science which were expressed within the program did not reflect a personal dislike of social scientists as individuals; rather, such comments mirrored somewhat stereotyped attitudes and assumptions held by clinical personnel regarding the value and role of social science. That is, team conflict is ultimately a derivative of disciplinary preconceptions about the importance and quality of another's work and worth. These preconceptions are brought into the situation as the result

of disciplinary affiliations and thus are not necessarily generated by it, but are, instead, triggered by it. Based on my observations, I would conclude in this case that team conflict between subcultures is based primarily on disciplinary affiliation rather than on individual personality.

Even the members of the medical team were somewhat aware of this phenomenon. During my early days of adjustment, when I responded on a personal level to their general comments regarding social science, they would caution: "You're taking this too personally. It has nothing to do with you." The following discussion of the "secondary" or "subsidiary" status of the social sciences, then, focuses on the separate status of social science within the team, not on any generic "low status" of social scientists.

It is also important to note that the social scientists proposed and expected to contribute to the team goal of health care delivery through program evaluation. In doing so, the social scientists constituted a perceived threat to clinical care givers who felt judged, and thus undercut in their clinical capacity. The resulting fear of social science evaluation, particularly on the part of the nurse practitioners, might account for part of the antagonism expressed by members of the medical subculture as they rejected the validity of social science input or evaluation.

The Physician's View of the Place of Social Science in Team Operations

A major obstacle in defining a social science role within the CHP team was that medical personnel did not value the evaluative research contribution the social scientists had been trained to make. To begin with, they did not fully understand what social science is or does. The physician was open in admitting his lack of social science knowledge: "I still really don't know that much about anthropology and sociology. I've been through self-training sessions and I have books at my bedside, but I'm still not satisfied." The doctor consequently did not feel "competent" to supervise the social scientists, mainly because he did not know what to expect of their role as team members: "I, the project director, did not know what their duties were. I really wanted the social scientists to define their own roles."

Although the physician did not understand exactly what the social science disciplines had to offer, his knowledge of and appreciation for social science was higher than that of any other medical team member. It was the physician who organized the initial team to include social scientists and it was he who continued to actively seek social science input. In creating the CHP team, he explained that he had believed it important to include anthropology as a part of health care in order to fully meet the patient's needs:

> I was having cultural problems with my patients. As a physician I was already attempting to take care of behavioral problems, but I wasn't, however, able to understand how the cultural factors came into play. I found this aspect of patient care to be extremely interesting and stimulating.

With this beginning, he continued to solicit social science input, because of its utility in practical problem solving:

> I think the every-day presence of an anthropologist is very beneficial. By their mere presence they increase our sensitivity to patient problems and that's very important. Many of the situations we deal with have to do with cultural factors. The social scientists don't do things for the team that are specific. They bring out ideas that I would never think of, that I can then utilize in practical problem solving. They have a point of view on the condition of man that is very much needed in a medical setting.

The physician was also specifically interested in program planning and evaluation:

> The social scientists have an important role in evaluating the team in its many aspects. Part of their role is to evaluate the CHP and to use that information to change our approach so that it is more efficient.

He even went so far as to state that medicine could not do without social science: "Your criticisms, your ideas, your point of view, they may be traumatic to you, traumatic to me, but they've got to be there every day." In summary, the physician was happy to include social scientists, respecting their work and valuing their contribution: "I would like to see the behavioral science group in the program increase in numbers, not decrease."

Nurse Practitioner Adversarial Perceptions of Social Science in Health Care Practice

Most other medical team members, however, did not share the physician's attitude. The nurse practitioners, in particular, did not believe social science to be "necessary" to the team. When questioned about the value of social science to the CHP, they responded variously:

> "None";
>
> "Is there any?";
>
> "We don't need a lot of social scientists to just sit here and look pretty"; and
>
> "The program could function very well with only Dr. X and the nurse practitioners. The multidisciplinary aspect is not necessary to program survival. We don't need an anthropologist or a sociologist in this program."

To the nurse practitioners, who actually knew even less about social science than the physician, social science looked "easy" and they knew there was "nothing to it."[1]

They claimed to be fully proficient in social science, by virtue of their status as members of the same minority as the Mexican American patients. As one of their fellow medical team members noted:

> They feel they can do their own social science as well as you, perhaps better than you, because they have so much in common with the patients as fellow Mexican Americans. They have had the same experiences as the patients and they obviously feel much more adequate in dealing with social science in this situation than you.

Statements of this type indicate a very rudimentary understanding of social science as nothing more than "something" which increases one's sensitivity to the patient. The physician also expressed this idea although he was able to move beyond it to a somewhat more sophisticated understanding of social science. As an Anglo, the doctor appreciated social science sensitivity to cultural factors. As Mexican Americans, the nurse practitioners did not. They believed they were already sensitive to cultural factors and that, in point of fact, social scientists did not understand cultural factors! This idea can be traced to their radicalism as self-defined "Chicanos" and will be discussed more fully in Chapter VII.

With regard to their more general attitude toward social science, it should be noted that while they believed they had nothing to learn, they actually did not comprehend the many disciplines involved in social science research or practice. In truth, the nurse practitioners were abysmally uninformed regarding social science. Their complete lack of sophistication is witnessed by the following statement in which a nurse practitioner attacked the first program anthropologist as "a liar:"

> I don't even know what kind of anthropologist he was because he lied about it so much. One day he was a cultural anthropologist, the next he'd be a medical anthropologist and the next another kind of anthropologist. What kind of an anthropologist was he in essence?

This nurse practitioner clearly did not realize or acknowledge that such statements are the equivalent of his calling himself a nurse, a nurse practitioner, a pediatric nurse and a pediatric cardiology associate. This type of comment may also reveal a fear of social science. All of the social science team members and several of the non-nurse medical team members felt the nurse practitioners to be threatened by social science. As one medical team member remarked:

> We don't yet know how to utilize the social scientists and we are usually afraid of things we don't know about. They're more secure in meeting the medical needs of the patients. It will just take more time for them to become comfortable with social science.

Not only did the nurse practitioners not understand the larger field in which the social science disciplines operated, but they did not understand how a social scientist could fit into team clinical services. As the physician noted: "The nurse practitioners have not really learned from their own experience where it is that social science enters into the delivery of health care." This could be seen even in their referrals of patients for psychological care. For example, they tended to make no distinction between the social worker and the social scientists, as is witnessed in the comment of a nurse practitioner who referred to the social worker as "the sociologist." In the social worker's absence, the social scientists responded to medical personnel's counseling referrals with a reluctance

never fully comprehended by medical personnel. This situation aggravated the social scientists. As one remarked in weary frustration:

> They don't distinguish between social workers and shrinks or social scientists and shrinks. They're all the same thing and the only role that really drops out is the great role of the social scientist.

Another complained in reference to being inappropriately referred certain, non-specific behavioral problems: "They think we're all in the same boat and any of us can take care of it. It's like giving a broken arm to the cardiologist." This situation was particularly frustrating to the social scientists, who never pretended to be expert in every aspect of social science. As one observed:

> Apparently people tend to think of sociologists in particular and social scientists in general as generalists. You study man, therefore you should be able to render an expert opinion on anything to do with man.

There are numerous other examples of a general lack of awareness of the varieties of behavioral science. Consequently, though the clinical team members knew that medical personnel specialize in certain facets of medical care, they ignored the reality that social scientists specialize in particular areas as well. Because clinical personnel did not comprehend the many disciplines within the field of social science, they tended to respond stereotypically to all social scientists as "social workers."

Nurse practitioner attitudes toward social science also revealed a strong anti-intellectual bias. The nurse practitioners demonstrated no respect for education or learning that did not equip one to become a practicing member of a lucrative profession. One nurse practitioner explained that he had chosen nursing as a career, after leaving the armed services, because it was a profession in which one could "make the most money with the least education." As with their more general attitudes toward the disutility of social science, the nurse practitioners were not hesitant in expressing their disrespect for scholars:

> People in the field do not view those in academia as being omniscient. As a matter of fact, the complete reverse is true. These highly-scholared individuals are the ones reading the nice papers saying things are getting tough in rural America. Who's writing them? Guys who haven't been in the field in twelve years.

This particular nurse practitioner went on to discredit all research as being "made up" in order to satisfy dissertation requirements, suggesting that research subjects would tell the researcher whatever they thought he wanted to hear.[2]

These negativistic attitudes toward social science were revealed most clearly in the nurse practitioner's reaction to the social science counseling class the physician requested they be taught. After the class was completed the physician was very pleased with the social scientists' efforts to organize and teach social science to the nurse

practitioners: "The educational program you offered was of great benefit to us all." The nurse practitioners saw it differently. They felt the class to be a "waste of time" and stated that they "could have done without it." They did not make these statements directly to either the physician or the social scientists. During the classes themselves, the nurse practitioners were passively resistant. They responded during the lecture/discussion classes by being inattentive, rude and contentious. In this manner, they refused to participate in class discussions.

When questioned directly about their attitude during the course of the social science class, the collective nurse practitioner response can be summed in the statement one made without hesitating: "You can't teach me; you can help me learn things but you can't teach me." Because of their lack of interest and cooperation the classes ended earlier than originally planned. Afterward, when questioned persistently about the attitudes they displayed in class, this explanation followed:

> You don't only want me to learn, you want me to practice. You want the social worker to practice nurse practitionership skills? I have enough to do. Then you all come out and say you want to teach. I don't want to be taught. If I want to learn then why didn't I just go to social school and become a social worker. Big Deal.

This quote clearly reflects the low esteem in which the nurse practitioners held social science and their

accompanying perception that they didn't "have to" learn about it. They did not have to, that is, want to, learn about social science because they did not see any benefit to doing so. In their analysis of the CHP team it was clear that all power, authority and monetary reward lay in the hands of the physician, or at least the clinical staff members,and certainly not with the social worker, and even less so with the social scientists. It was the goal of the nurse practitioners to be the right-hand men of the physician, to be indispensible, to practice medicine and nothing more.

In pursuing this goal, they were perhaps particularly attempting to acquire power. As one of the nurse practitioners states in remarking that he would give up his next salary increase if allowed to join hospital committees: "I'm not money hungry; I'm prestige hungry." He continued, demonstrating his unhappiness with being treated as a nurse rather than as a physician:

> We don't have hospital staff privileges. I'm not officially here. You get invitations to this and to that. I don't get them. I'm not invited to attend physician functions.

The respect of the nurse practitioners seemed to be reserved for physicians,[3] as they defined themselves in terms of physician roles:

> My diagnosis will go up on the chart and the doctor that comes and treats the patient will be working off my diagnosis. The nurse practitioner is the most important aspect of this program.

They saw their role as being in transition, from being the "peers" of nurses to becoming the "peers" of physicians:

> Everyone expects the nurse practitioner to be happy because they're getting a good salary and Dr. X loves them, but I have other concerns. I have needs for reputation with my peers, with those nurses who were my peers and with those pediatricians who will be my partners in the future.

Even the social worker, although certainly accorded more acceptance and respect as a fellow member of the medical team, felt the pressure of medical dominance. When participating in funding/public relations trips, he always introduced himself by stating: "I'm just a social worker." He was teased about this by the nurse practitioners, who gave him a sign hand-lettered with the phrase "Just a social worker." He placed it on the wall above his desk.

A further indication of the devalued or "second-class" status of social science was that the social scientists were the butt of one-way humor directed at them by the nurse practitioners. This kind of derogatory humor usually flows from those with a central role in an organization toward those who are marginal. It is not returned.[4] In the CHP team, the social scientists were nicknamed, as behavioral scientists, the "B.S.ers" and social science discussions were referred to as "bullshit sessions."

Historical Antecedents of Hiring Social Scientists on the CHP Team

The low status of the social scientists within the CHP team as perceived by other team members was further exacerbated by the conditions under which the anthropologist and sociologist were brought into the team. As the first anthropologist was preparing to leave, he proposed that two Ph.D.-level students replace him, each of whom would receive half of his salary. These students were to be given the opportunity to do their dissertation research during their temporary nine-month positions as team members.[5] The final stipulation was that the social scientists would be "supervised" by a member of the medical team, the social worker.

The anthropologist and sociologist were not informed of the latter arrangement prior to their being hired. The social worker himself took no steps to assert any authority over either until they had been with the program for several months. They discovered this arrangement after the social worker wrote a memo explaining "the place of social science" within the CHP team, signed his and their names to it and distributed it to all team members, all without consulting either of the social scientists. When confronted about this, the social worker informed the social scientists that as his supervisees they would be following his instructions in the future. The anthropologist refused to do so, stating that she had not been told this before agreeing to work with

the program. She threatened to quit if the social worker pursued the issue. The matter of supervision was never mentioned again until the very end of the social scientist's full-time tenure with the program, at which point the director stated he was "disappointed with the social worker for not taking more leadership initiative with the social scientists."

The conditions under which the social scientists were brought into the program conveyed to medical personnel the idea that two "students" were the equivalent of one "real" anthropologist. Additionally, social scientists were seen as being subsidiary to medical personnel to the point of necessitating supervision by a non-leader member of the medical team. All of this served to reinforce the already low status of social science within the program. As temporary workers, the social scientists were further set apart from the concerns of permanent team members. They were not, for example, nearly as interested in funding as they undoubtedly would have been had their future careers depended upon it. Also, as the most recently hired members of the team, the anthropologist and sociologist were in the vulnerable position of newcomers. This fact alone placed them in the "one-down" position always held by foreigners. Unfamiliar with program history and norms, they had to feel

their way in many situations in which other team members could move more surely.[6]

In splitting the full-time salary ($18,000) of the previous Ph.D.-level anthropologist, the anthropologist and sociologist earned the lowest salaries of any team member except the secretary-coordinator. In comparison, the nurse practitioners, who held two year associate of arts nursing degrees, were paid between $16,000 and $18,000 while the M.S.W. level social worker earned $18,500. The physician probably earned more than all team members combined.[7]

Salary and tenure were objective conditions determined by the team. The response of the social scientists demonstrates their subjective reaction to working conditions. The social scientists resented their low salary in comparison to the earnings of other team members. This produced a continual sore point for them. As one of the social scientists noted: "I feel resentful at being paid a lower salary than anyone else." One way in which they reacted to this was by continuing to dress as "students" rather than as professionals. The sociologist and anthropologist, for example, often wore jeans, knit or cotton shirts and leather shoes in contrast to the nurse practitioners who usually attired themselves in jersey, double knit and patent leather outfits topped by white coat and stethescope. The anthropologist was once enthusiastically introduced by one

community physician to another: "She may not look impressive, but she's a real anthropologist."

Their manner of dress was partly a reaction to economic reality for on their minimal salary they could not afford to purchase professional clothing. It was also, however, a reaction to their perception of the low regard for social science within the program. Because they did not feel accepted as team members, they preferred to remain attired as they had when playing the role of students, a role in which they felt secure. Their manner of dress, of course, only served to further reinforce their separateness from the rest of the team.

The Predecessor of the Social Scientists

Status differentials between social science and medical personnel can be further clarified by considering the status of the first anthropologist. He did not have to contend with the onus of being classified as a student. He entered the team as a recently graduated Ph.D. and was referred to respectfully by some as "Dr. A." Dr. A was a team member during a period in which the first three nurse practitioners were in training. In this situation, the anthropologist had considered himself to be the superior of the nurse practitioners. They were undeterred by his opinion and just as clearly considered themselves to be his superiors. As one of the nurse practitioners described "those days:"

> The nurse practitioner was being educated and everyone thought the nurse practitioner was the low man on the totem pole. I can assure you the nurse practitioner never saw it that way.

This is the way the nurse practitioners "saw it:"

> Dr. A tried to tell me "I didn't go to school all these years to become a doctor of anthropology, and come here to listen to the likes of you!" He tried to tell me he was superior because of the training in his field and I told him that I had been taught that I was the next thing outside the patient and that I was the coordinator of all other services, including him. He was ancillary as far as I was concerned.

What ensued can only be described as a gigantic power struggle in which the anthropologist, and whatever clinical counseling practitioner was currently working with the team were ranged on one side and the medical team personnel were entrenched on the other.

The first anthropologist was the only team member to address the physician by first name, as "John." This was symbolic of his view of himself as an equal to the physician and thus as superordinant to other team members. This stance infuriated the rest of the team. Even after his departure, the first anthropologist's name was often mentioned resentfully, even angrily, by every member of the team but the secretary-coordinator. Most often criticized was his casual adherence to the medical team's working schedule. As a nurse practitioner angrily complained:

> Why should we start working at 7:30 or 8:00 in the morning and he could come in at 9:00 or 10:00 and have coffee for a good hour and yap for an

> hour. Like I say, he was very good at talking and he could go on forever and then go out to eat at noon. We'd work till 5:00 or 6:00 at night. Come four o'clock and he's gone. And of course he's been paid approximately what we were or even better.

Others noted that, while in the office, "Dr. A sat at his desk most of the time, with his feet up, and nobody knew what he was doing or why he was doing it." This latter comment indicates that Dr. A experienced the same difficulties in role definition as did the second anthropologist and the sociologist. With Dr. A, however, there was the additional problem of his assumption of high status.

More than the hours he worked, team members were annoyed by the fact that he considered himself to be "bigger than everybody else." As one nurse practitioner succinctly stated: "Dr. A's problem with time wasn't that he came in late, but that he bragged about it. He seemed to think 'I'm more important than any of you and I can come in any time I want.'" In assuming a position of privilege, the first anthropologist was acquiring a position not accorded him by any member of the program. As another medical team member noted of Dr. A:

> He said 'I don't like to get up early in the morning' and 'I was reading the paper.' Everybody would like to do that but nobody else was allowed to. They couldn't figure out why he was allowed to when they weren't.

As the physician would later note: "It wasn't that I was purposely disrespecting the first anthropologist, but how

could I take his side just because he was a Ph.D.?" Without a power base, the anthropologist's attempt to define his own status was doomed to failure.

The first anthropologist's relationship with the team ended some months after his departure to another town to assume a new position. After leaving the team, Dr. A made several return consulting trips during which all arrangements were handled by the team technician-administrator. Dr. A believed he was being treated disrespectfully by being forced to communicate with the technician-administrator, Dr. X's subordinate, rather than with Dr. X himself. Dr. A sent word of his dissatisfaction, indirectly, through the program economist, at which time the physician refused to treat him "any differently" than anyone else. Dr. A subsequently made no more consulting trips.

Social Scientist Reaction to the Reality of a Non-Egalitarian Team

The secondary status of social science within the program placed the social science personnel in a precarious position. Program members expected the social scientists to adapt to the team and did not expect to make any corresponding changes of their own. Attempts by the social scientists to adapt to the program were impeded, moreover, by the team's description of itself as something other than what it actually was: an egalitarian, interdisciplinary health care team. In attempting to define and negotiate

their own rules, the social scientists discovered that they would not be given sufficient latitude to do so freely. Denied a place on the team as social science researchers, they grappled constantly with the problem of how and how much to adapt. The expectations of the medical team were clear in that they expected the social scientists to do "something" of practical value to the team but murky insofar as the "something" remained undefined. As one of the nurse practitioners stated:

> I see the social scientists doing their own thing. I think they should be working with us, not above us, not below us. I think they should be working right along with us.

What the social scientists were supposed to be doing "right along with him" remained a larger question. When the team stated "You tell us what your role is going to be," the social scientists finally came to understand that "researcher/evaluator" was not going to be an acceptable answer. What team members meant, more precisely, was: "You tell us how you are going to fit into what we are already doing here as practitioners." Even the physician held this attitude. As one social scientist noted: "Dr. X may not know exactly what we're supposed to be doing, but he wants us right in there doing it."

Most medical team members came to an eventual understanding of the difficulty the anthropologist and sociologist experienced as newcomers to the team, finally agreeing

that the medical team had been "cold and unfriendly." Beyond this, however, only the physician seemed to have any insight into the problems of role definition which the social scientists continued to face. It was he who noted: "I think it's too bad that you have had to spend so much time being accepted by the subculture." He also commented sympathetically that he believed the social scientists on the team did "not feel appreciated very much." This was true. Social science team members felt decorative, like "window dressing." As noted in the previous chapter, the social scientists were in fact angered by their lack of acceptance in the program. As the sociologist remarked about himself:

> I feel that I am a token social scientist in the same sense that in the mid-1960s we used to talk about the token black, the guy who sat in front of the window so everyone could see him. It seems that the only reason for my being on this team is so we can say on grant proposals that we're an interdisciplinary team with a lot of social scientists.

Further complaints of the social scientists about their participation in program activities were:

> No one has really made an attempt to learn what I am doing, or what makes me tick, or what I hope to contribute.

> I have to prove myself to medical personnel and not vice versa.

> Although I was hired by the CHP as a team member I find myself in the strange position of having to sell myself as a social scientist after my arrival.

The social scientists were not only not "understood," they were also attacked on a personal level as being "poor social scientists." As one of the nurse practitioners explained: "The social scientists who have come here to work have not been true social scientists. This is clear because they have had more behavioral problems themselves than the clientele we serve." The inclination of members of both subcultures to blame team conflict on the "personality" of team members from the other subculture will be dealt with thoroughly in Chapter VII. The nurse practitioner's declaration that team social scientists were not "true social scientists" is important because it underlines the clinical team members' pervasive uncomplimentary view of social science in general. As with the one-way humor mentioned in a previous section of this chapter, these disrespectful, negative feelings were unidirectional. Although social science team members were upset with medical team members for various reasons, including their personal foibles, they never accused medical personnel of incompetence in their clinical work. As one of the social scientists reported in frustration:

> I don't resent the medical staff, or think they're stupid, or that they don't have an important role to play, but that's what the medical people seem to think about the social scientists.

Summary

This companion chapter to the previous chapter on medical dominance has explored the secondary status of social science, the mirror side of clinical bias. To this point, emphasis has been on documenting the existence of separate medical and social science subcultures and on outlining clinical domination and consequent social science subordination. This kind of symbolic degradation of worth is the predicament not only of social scientists who enter the medical system, but of all outsiders who attempt to gain access to this professional arena.

Within the medical subculture of the CHP team, the nurse practitioners were seen to have the most strongly negative attitudes toward social science. They were uninformed about social science and, knowing little about it, believed there was "nothing to it" and that they could do it themselves "if they wanted to." They did not want to do social science, however, preferring instead more physician-like, high-status activities. The historical antecedents of hiring the sociologist and anthropologist also offer evidence of the subsidiary position of social science. Both social scientists were placed in a subordinate position in the CHP team as a result of their "student" status, temporary positions, reduced salary and initial expectation that they would be supervised by a non-leader member of the

medical subculture. The first anthropologist's unsuccessful attempt to acquire status reveals further proof of the reduced circumstances in which social science team members inevitably found themselves.

The social scientists' reaction was predictably one of frustration and tension. Expecting to be a vital part of an interdisciplinary team, they found to their dismay that they were expected to remain in place on the sidelines, functioning more as a supporting cast than as co-players. It is to the subject of role performance that we turn in the next chapter. We will discuss the manner in which the clinical bias of the CHP team led members of the medical subculture to feel free to tell the social scientists what to do and how to act as team members.

Notes

1. An analogy can be made between the nurse practitioner's belief that they could "do" social science if they "wanted to" and the idea held by most Americans that they can write poetry.

2. This nurse practitioner critized social science thus:

> How often do you give the poor peon Mexican American an opportunity to speak amongst so highly scholared individuals as you? Here you are working on your Ph.D.s and here you got a bunch of guys who say "I want to get my words into that guy's chapter." They'll tell you whatever you want to hear.

3. This is also reflected in the decision announced by two of the four nurse practitioners at the end of my second research year. They decided to leave the program in

order to enter medical school in Mexico. Even I seriously considered the possibility of training as a physician.

4. Hyman Rodman and Ralph Kolodny (1971) encountered this phenomena while working as researchers on a team of mental health practitioners. However, after giving examples of one-way humor they describe the humor as being "sarcastic, but kindly" (1971:128), going on to state that it was directed "not downward but sideways" (1971:129). To my mind there is nothing "kindly" about such humor unless, perhaps, one prefers being acknowledged to being ignored. Also, at least in the case of the CHP, this humor was clearly directed downward at the members of the subculture seen to have the least status: the social scientists.

5. The positions were designed to end with the coming of the new fiscal grant year.

6. The economist, although not as new to the team as the sociologist and anthropologist, had less tenure within the program than most other medical team members. He too was enrolled in a graduate Ph.D. program. Additionally, his position was part- rather than full-time.

7. The physician received no salary from the grant. In theory he "donated" fifty percent of his time to the CHP and spent the rest in his private practice. In practice, the physician's public and private clients were mixed under the auspices of the CHP, a situation which caused the physician and various team members not a small amount of anxiety and discomfort. Although no one knew the physician's exact yearly income, it was the pastime of some team members to try to make an educated guess. It was obvious to all that the physician was markedly more prosperous and lived a higher life style than any other team member. He owned three residences, for example.

CHAPTER VI
SUBCULTURAL DIFFERENCES AND ROLE CONFLICT

It has been shown that the social science and clinical subcultures in the CHP team operated as two segregated units within the officially designated team and that the implicit and explicit dominance of the clinical members inhibited the social science subculture from making the contribution to the team which it felt capable of delivering. Because the social scientists were under constant and heavy pressure to "adapt" to medical expectations, and thus to the established ways of doing things, they were constrained from functioning in roles of their own choosing.

Restated, the social scientists wished to work as researcher/evaluators, and in doing so they had anticipated developing innovative ideas concerning health care delivery for the consideration of other team members. Instead, they found themselves "besieged" on all sides, and much of their energy was diverted to the task of determining exactly what was expected of them and then deciding, given their disciplinary-subcultural background, whether they could or would be able to produce the desired services.

Role conflict on the CHP team resulted from subcultural differences between the social science and

clinical groups. The purpose of this chapter is to illustrate and to explain that conflict by analyzing these subcultural differences in depth.[1] The analysis utilizes differences in goals and values as an explanatory device. This allows us to more clearly delineate the origin and specific characteristics of role conflict on the CHP team. It will be seen that differences in goals and values resulted in two critical points of role conflict in the team's daily operations: first, when members of the medical subculture seemed to suggest that the social scientists perform clinical work and, secondly, when medical personnel attempted to influence the manner in which the social scientists carried out their research. Each will be examined in detail.

Subcultural Differences

Before initiating a discussion of differences in goals and values between the two subcultures of the CHP, it will be useful to examine the "typical day" for each. This provides a means of illustrating the variation in day-to-day work patterns as revealed in type, scheduling and location of work. So significant were the differences in work behavior between the two subcultures that medical personnel actually criticized the social scientists for "not really working." For their part, social science researchers critiqued clinical team members as being "insufficiently thoughtful."

The "Typical Day" of the Clinical and Research Subcultures

The range of daily or weekly activities in which each team member participated is detailed in Appendix B, "Percentage of Work Activity for Team Members."[2] A typical day, however, necessarily differs from the composite picture presented in that appendix. A typical day represents an ordered stream of activities that commonly took place in the team-patient setting. The typical work day of medical personnel usually began at 8:00 a.m. (they occasionally arrived earlier to attend or teach a hospital training session) and did not end until 5:00 or 6:00 p.m., after the last patient of the day had left. Clinical team members also worked during certain hours of the weekend, usually on Saturday mornings. The clinical day was tightly scheduled and included such activities as patient care, grant submission and public relations. This was particularly true for the nurse practitioners and the physician, who were busiest when patients were present. Their mornings were usually spent in making patient rounds and attending the patient management meeting. Their afternoons were occupied screening outpatients, either in the hospital clinic or in one of the Basin clinics. All medical work took place either in the hospital or in the outlying clinics.

The work schedule of the nurse practitioners was not identical, since funding and public relations activities

drew their attention to varying degrees. Appendix B reveals, for example, that nurse practitioner 1 devoted considerably less time to patient medical care and consequently more time to funding and public relations activities than nurse practitioner 2. Appendix C also indicates that medical staff not immediately involved in direct clinical care had some latitude in scheduling their work responsibilities.

A typical work day for the anthropologist began at 7:30 a.m. teaching an hour-long class on social science to medical personnel (for example, on the topic of physician-patient relationships). The remainder of the morning would be spent attending the patient management meeting, observing and contributing to patient review and collecting and organizing material for another social science lecture. This work was carried out at the Children's Hospital library and at her CHP desk. Lunch might include discussing program activities with an outside visitor or consulting with other social scientists about research plans or programmatic affairs. Typical afternoons included further observation of team interaction and patient management and in typing and review of fieldnotes for this study on teamwork. Evening hours at home were often necessary for evaluating work progress and for planning and organizing the efforts of the coming days or weeks. The particular work activities in which the anthropologist engaged in any one week varied

according to the stage of her research efforts. In the early months of research, for example, significantly more time was spent observing team meetings, reading patient files, attending patient examinations and traveling to the Basin clinics. Later, less time was spent in meetings and observations and more energy was devoted to individual staff interviews and compilation of the data thus gathered. The typical day of the sociologist was similar to that of the anthropologist, differing only slightly in detail. He tended, for example, not to take the Basin trips as frequently and spent more time than the anthropologist on administrative and secretarial tasks.

Superficially, it appears that the social science and clinical team members were fully occupied in different but clearly defined activities. That such was not the case will be revealed in subsequent discussion of the manner in which the two subcultures differed in their perceptions of "appropriate" goals and values. To generalize, each subculture tended to see the other in a critical light, as too narrowly focused. This became a source of significant conflict, conflict which contributed negatively to the smooth operation of the CHP team.

Goals

Medical members of the CHP team were engaged in two readily-quantifiable activities. The goals of most

importance to the medical/clinical subculture were provision of medical and psychological care for CHP patients and maintenance of continued program funding. In contrast, team members from the social science/research subculture had research as their goal. These differences in goals led, not surprisingly, to the significant differences in time and work allocations detailed in the discussion of the typical day of each subculture.

Medical personnel concentrated their efforts on clinical care and program funding. In theory, their primary goal was the provision of health care; in practice, funding activities were rated as being of equal if not greater importance. This was a practical response to the realities of program funding; without funding, the team would have been forced to disband. Awareness of this situation led one medical team member to conclude: "The primary goal of this program is to make sure we have enough money to continue."

As a recipient of federal and local grant money, the directors of the program had to reapply for funding each year. Although this was an enormously time-consuming endeavor,[3] medical team members did not view funding responsibilities as completely burdensome. Rather, some saw them as the most "exciting thing" going on within program operations. One member admitted, "I wouldn't get any kicks if I couldn't go to Washington every once in awhile."

None of the three social scientists was able to provide direct medical care, although the anthropologist and sociologist did some back-up counseling in the social worker's absence. The economist participated in funding activities, but both the anthropologist and sociologist eschewed any involvement in funding. The sociologist believed, and the anthropologist concurred, that it was the responsibility of social scientists, "not to fund-raise but to collect data of use to fund-raisers."

The anthropologist and sociologist were concerned with planning and implementing comprehensive health services, that is, with providing care to meet the emotional and social, as well as medical needs of consumers. As the sociologist argued, it was the purpose of the CHP to deliver well-rounded health services:

> All this boils down to treating people as human beings, not as "the tetrology of phallot in Room 12." We don't want to treat people like hearts with arms and legs attached. With this in mind we try to deliver cardiological services to the maximum number of people.

This is not to suggest that members of the medical team were not interested in providing "total" health care. They were.[4] Their stated primary goal was the provision of interdisciplinary health care. The difference was that members of the medical team were confident, generally speaking, that they were already providing the best possible health care. Social science team members, on the other

hand, did not share this conviction and were thus more critical of the current system. In an evaluative frame of mind, they asked such questions as: "What kind of health services are being provided?;" "Are these services the most effective means of providing 'total health care?'" and "Should program services be reorganized to improve efficacy/efficiency?"

The social scientists had been hired with the expectation, by members of the medical subculture, that they would work with the team in some undefined capacity to provide interdisciplinary health care. The social scientists expected to be evaluator/critics of program operations. The social scientists saw their role in delivering the comprehensive services they so highly valued as being squarely in the realm of program planning, evaluation and monitoring. Both considered evaluative planning to be a primary factor in ensuring the future survival of the CHP. By evaluating the program's efficacy and efficiency, they wished to improve the quality of care delivered. They believed that the necessary grant money would automatically follow. As the anthropologist noted with regard to the role of social science in evaluating program activities:

> Social scientists ask impertinent questions and make unwanted criticisms. They try to understand and evaluate a program's functioning and thus to allow a program to take stock of itself. This information about what is actually occurring

within a program can then be used, in careful planning for the future, to strengthen a program's position.

In addition to their program planning/evaluative efforts, the anthropologist and sociologist also taught social science to medical personnel, to hospital residents and nurses and to the CHP nurse practitioners. Teaching provided them another means of encouraging the delivery of comprehensive health care. Their teaching was research-oriented as they spent considerable time reading and reviewing social science literature in preparation for their classes. The economist, who did not teach, did some research in which he attempted to present the program in a favorable light. His main contribution to program operations as a part-time worker came in the form of budget management of the CHP's grant money. In his own words, he considered his role to be that of a "financial systems analyst." Because his work responsibilities were more "practical" or concrete, and because he was only a part-time team member, the economist did not suffer the same problems of role conflict as the anthropologist and sociologist.

While it was relatively easy for the medical personnel to account for their time by counting patients seen, grant applications submitted and funding/public relations trips completed, the major tasks of the social scientists--social research and teaching--were neither highly visible nor

easily understood qualitatively by other members of the team. In the case of research, the choice of method affected how the social scientists were seen by other team members. Both the anthropologist and sociologist were qualitative methodologists. As a result, their work was even less visible than quantitative work would have been. Techniques such as participant observation, for example, do not involve the use of questionnaires or statistical manipulation of gathered social data. Traditional research based on the classic Fisherian model using control groups would have been a form of research more familiar to medical team members.[5]

The social scientists' research labor was variable and loosely organized into a variety of tasks including reading, interviewing or other qualitative forms of data gathering, recording and analysis of research data, discussing research progress or results and/or writing. All of these research tasks were more fluid and less obviously directed than comparable patient-related tasks. Rather than performing certain standardized medical procedures on patients, the social science activities were perhaps more akin to figuring out a puzzle which had many possible solutions. This kind of puzzle-solving work, of course, is enormously time-consuming and often slow-moving.

The same situation existed with regard to the time social scientists devoted to teaching responsibilites. The long hours of reading, analysis, writing lecture notes and so forth did not produce highly visible or easily quantifiable results. When the nurse practitioners "taught" other medical practitioners about heart disease, they did not use this method of preparation and presentation. They worked from previously prepared materials which covered certain learning objectives and contained tests for measuring the achievement of these objectives. Using this format, they then presented introductory material of a highly technical nature. The social scientists, on the other hand, prepared a wide-ranging series of lectures which attempted to cover the relationship between many facets of social science knowledge and the general field of medicine. They read widely, critically analyzed the material they had covered and then used this information to present opposing ideas rather than "facts" of social science.

This difference in method caused considerable conflict between medical and social science personnel.[6] Medical personnel complained that social scientists spent much of their time either talking or reading. They did not consider either to be "work." With regard to talking, medical personnel believed talking to be a waste of time. As mentioned in the previous chapter, the nurse practitioners referred to

social science discussions as "bullshit sessions," nicknaming the social (behavioral) scientists the "B.S.ers." The nurse practitioners did not want to "discuss" alternatives, then choose among them, as the social scientists encouraged them to do. Instead, they demanded: "When I ask a question, I want an answer, yes or no."[7] The physician had somewhat the same attitude toward discussion. He requested that cases be discussed during patient rounds, noting that although he preferred this setting, social scientists seemed to avoid it:

> I'd like to learn in a natural setting rather than in a lecture-type setting. I think you all have a difficult time doing that. I kind of get the feeling sometimes that you don't know how to do that.

Yet another problem lay with reading. "All he ever did was read," one medical staff member complained about the first anthropologist. Medical personnel did not consider reading to be work; rather, it was something that was done "for fun." As a nurse practitioner once stated angrily: "Who the hell around here doesn't want to read if they have the time?" The physician also declared himself to be "too busy" to read: "It seems the social scientists are always giving me something to read."[8] The sociologist was moved by all of this to exclaim: "It seems that if you read something around here you are breaking a social norm."

The medical subculture's perception of talking and reading as being something other than "work" led to their notion that the social scientists were "not really working." For example, one of the nurse practitioners announced one afternoon at work: "I might just take off for the day, pull the social science bit and go work at home." On another occasion, a medical team member was criticized by another for taking a somewhat extended lunch hour: "Just who do you think you are, a social scientist, that you can take a two-hour lunch break?" Although social scientists might have used lunch as an opportunity to discuss work or to cultivate outside contacts, medical staff tended to think that work responsibilities were not a part of lunch activities.

One member of the medical team with whom the social scientists shared office space, the secretary-coordinator, was sympathetic to their position:

> The medical staff have a certain goal they want to reach and they just don't see the implication of your work, or how busy you are in collecting your data, or even what you're going through. I'm sitting at my desk and I see all this. Their main objective is to treat the patient and get him out; he's either cured or not. I don't think they see how your role fits into what they are doing.[9]

And with regard to program complaints that the first anthropologist read "too much:"

> He could walk in at 10 or 11 a.m. and leave whatever time he wanted. But they didn't see what time he was spending at home reading and I don't think they ever really believed he did very

> much. No one knew what he was doing, but he was constantly busy, and every once in awhile he would be in his office reading a report or something and they would walk in and say "Wish I could sit back and read," and they do sometimes.[10]

The nurse practitioners' idea that the social scientists spent all their time talking and reading or "having fun" as one social scientist sarcastically put it may suggest that they were jealous of the social scientists because they were unhappy with their own role. "After all," ventured one of the social scientists, "that's pretty boring stuff they do." The nurse practitioners were locked into a strict daily round of responsibilities and did not have the freedom to set their own schedule. Although under just as heavy a work load, the position of the social scientists may have seemed less onerous because of the flexibility of their work schedules. A certain feeling of boredom with seeing patients is reflected in this nurse practitioner's statement to a program visitor:

> We're stuck with our name, The Children's Health Program. We spend only about thirty percent of our time working with patients, yet all anyone who visits wants to know about is the patients and the program.

The differing work activities and work rhythms demonstrated in the typical day of social science and clinical subcultures reflects a difference in the goals selected by the members of each subculture. Goal selection, moreover, is determined by the values held by each subculture.[11] The

next section explores the differing values held by members of the two subcultures of the CHP team. Because the values were substantially different, they had major impact upon team functioning. Indeed, the primary distinction between the medical and social science subcultures within the CHP team can be traced to these differing values.

Values

The most obvious contrast in values between the two subcultures was between the medical scientist's emphasis on action and the social science concentration on reflection. Such a "thinker" versus "doer" or "head" versus "hand" duality is, of course, oversimplified and is not meant to suggest that medical personnel did not think or that social scientists never acted. Yet members of the CHP team tended to define themselves and other team members in just these terms.[12] The following quotations demonstrate the proclivity of each subculture to criticize the other for "thinking" to the exclusion of "doing," or vice versa. Medical members, for example, criticized the social scientists with such comments as:

> I've lumped people into doers and thinkers and I like doers. I guess I'm not really an academic, thinking-type person. It just doesn't fit my central nervous system. I get my kicks out of doing.
>
> The social scientists spend so much time discussing things that they never get around to doing anything.

> Social scientists never do anything.

The social scientists countered with:

> I like to know "what is" before acting.

> Medical personnel are there to change things. Social scientists are there to understand first, then to change things.

> The medical people are so busy doing things, they never stop to think about whether their actions are justified.

It is evident from this list that members of each subculture were critical of what they perceived as the values of the other. Such perceptions were a reflection of both the difference between the responsibilities involved in research-work and clinical-work and of professional socialization. The social scientists were trained by their discipline to do research, to "think." The clinicians were taught by their professions to provide therapy, to "do."

It was the sharpness of this perceived rift in value orientation that led members of each subculture to criticize the other. Social science team members felt that medical personnel never stopped to reflect and that, as a result, some of their activity was "senseless." To the social scientists, it appeared that medical personnel were so busy performing certain duties that they did not take the time to consider whether their actions were justifiable.

By contrast, medical team members obtained the impression that the social scientists were never "doing" anything.

An example of this is provided by the occasion on which the anthropologist presented a somewhat lengthy and detailed explanation of her teaching and research responsibilities to the nurse practitioners. Their response came quickly: "Is that all?" In another instance, the physician advised the anthropologist to "do" more things for the good of her future career development. He recommended going everywhere to get any and all experience, "even without a reason to do so." The anthropologist, however, did not like to act "without reason" and already believed that she was "doing plenty."

Role Conflict

Having established the differing goals and values held by the two team subcultures, we will now turn to a discussion of the role conflict engendered by these distinctions. In so doing, the reality of non-team functioning will be documented on the basis of two specific and closely related types of role conflict: whether the social science researchers would perform on-the-line clinical (non-medical) and funding work, as did the medical team, and whether the social scientists would specialize in research.

Critical Role Conflict I: Social Scientists as Unwitting or Unwilling Social Workers and Fund-Raisers

Although both social science and medical personnel adhered to the same overarching goal of "delivering comprehensive health care," members of each subculture held

differing assumptions about how best to do this. Medical staff actively sought to "deliver" comprehensive care by seeing patients and by seeking funding. The social scientists, assuming that critical evaluation was the necessary approach, sought to discuss and so to "plan" the delivery of comprehensive health care through their teaching and research activities. In this manner the differing value orientations of each subculture with regard to action and reflection determined the goals each chose to pursue.

The specific goals of each subculture determined the roles subsequently played by its members. The social scientists, therefore, acted as researchers and teachers, the medical personnel as clinicians and fund-raisers. This situation resulted in a form of role conflict in which the social scientists were often asked to assume roles similar to those held by the medical team; that is, as counseling clinicians and as fund-raisers. As a rule, these were roles they did not feel comfortable in assuming.

In requesting the social scientists to work as fund-raisers and clinicians, medical personnel were demanding more "concrete" work:

> I think a lot of the problem around here has been that a lot of social science has been channeled into research. We, however, look at things from a practical point of view and we need clinical application: things that we can see, concrete evidence that social science is important.

This "practicality" is what they admired in the social worker: "We can see his work."

The social scientists, however, were uncomfortable acting as social workers in the program,[13] insofar as the social worker's position involved overcoming the patient's fear of medical treatment. Medical personnel's ideas about how the social scientists might function as counselors were what concerned the social scientists. The following statements regarding such an action-oriented role for social scientists were made by medical personnel:

> The role of the social scientist is to identify the fears of the patient.
>
> The social scientists can help get through to people we can't who are refusing further treatment.
>
> Anthropologists should turn people on to medicine.

Although the social worker did function in this role, the social scientists preferred not to act as advocates of the program in this manner. They believed patients should make medical choices based on their own interpretation and weighing of medical advice.[14]

Medical personnel also expected the social scientists to participate in fund-raising. Members of each subculture, however, held very different ideas regarding funding. The social scientists saw funding as an obligation which diverted team activity from more important goals. One social

scientist lamented: "We pay a great price for having to put so much energy into funding." Nor did the social scientists feel comfortable in soliciting funds. They believed such activity removed them from the objectivity they wished to maintain as researchers by placing them in a partisan role. As one of the social scientists noted in explaining his position to medical personnel:

> The more you become a part of something the harder it is to stand off and take a passive viewpoint and evaluate it objectively. When you get into the area of public relations and publishing, you are working for the team actively as its agent.[15]

The social scientists criticized medical personnel not only for investing "too much" energy in funding, but also for being "deceptive" in their public relations/funding statements concerning program achievements. For example, the anthropologist noted that the CHP was misrepresenting the project's patient load to outside agencies by counting each patient visit as a separate patient. When she objected to this practice, clinical personnel explained their actions: "Everyone does it and we have to do it too, to keep up." Rather than accepting this as possibly an accounting of the behavior of beleaguered grant recipients trying to cope with the demands of federal reporting procedures or the statistical inflation of other programs, she continued to protest.

For her position the anthropologist was criticized as being impractical and unresponsive to the daily exigencies of program funding. Medical personnel accepted funding as a practical reality of life. With this in mind they desired the assistance of the social scientists and were puzzled by social science refusal to become involved. "You are missing a very important part of program business by not knowing about funding," the physician complained. The social scientists responded by continuing to ignore funding. On one occasion when the issue of funding was raised during a discussion of programatic goals, the anthropologist requested that the program "leave the question of funding out of this discussion." The physician responded in frustration: "We can't; we'll die. We're talking about our livelihood." On another occasion he noted:

> I know you think it's wrong, but I just can't help thinking about funding. It's important and we have to consider it in discussing the way in which our program is going to grow.

Critical Role Conflict II: Social Scientists as Program Advocates and Public Relations Representatives

Another form of role conflict developed when medical team members requested that the social scientists produce public relations materials for the use of the program. Whereas the research team wished to do critical evaluative research, it seemed to them that medical personnel would not be content with any material that was not either supportive,

or "affirmative," evaluation or public relations. For example, to the social scientists the physician appeared to be interested in program evaluation mainly to document program accountability for funding agencies. It was Dr. X's expectation that everyone would review all materials which members of the team wished to publish:

> In order to keep up with funding, when articles go out you must remember that the articles don't represent just you but the whole program. There should be some sort of a system of review, they should be reviewed by all of us. Everything should be reviewed before it is submitted for publication.

The social scientists, however, preferred not to produce "research" under such a system of review and they did not consider the possibility of producing both research and public relations materials within the confines of the team's "system." Very concerned about what other social scientists might think of such an "unprofessional" juxtaposition, one social scientist remarked to another: "You could crank out a couple of public relations articles which you could put in some medical magazine and your peers would never see it. You have to play show and tell with the CHP." All in all, the social scientists were frustrated with medical team members: "They don't want evaluation, they want PR artists."

Medical personnel were equally critical of the social scientists. They waited for the public relations

publications of the social scientists and wondered why they never appeared. "We were led to believe that you people would be firing off these papers. Where are they?," one nurse practitioner inquired. When asked how the social scientists could have contributed more effectively to program operations, the physician responded: "I would have liked to have seen papers come out. I probably would have liked to have seen you all get involved in funding." Aware of these feelings, the social scientists lamented: "Because they confuse public relations and research, and because we don't want to do public relations, we seem recalcitrant."

Given their perception that the medical team was interested only in PR, the social scientists reacted in a resentful and rebellious manner to what they interpreted as further attempts to direct them in their research endeavors. In one instance, for example, the nurse practitioners informed the social scientists: "If future social scientists want to be accepted then they will have to study us. That's their job." The social scientists believed that what the nurse practitioners desired from social science "study" was not evaluation, but publicity concerning the expanded role of nurse practitioners in medical care.[16] The social scientists became sensitive to what they perceived as pressure to conduct only certain kinds of research and to do so within narrowly prescribed limits. As one social scientist

complained: "'Why' questions are inappropriate around here. The social scientists are supposed to be implementing medical will. 'How' questions, not 'why' questions are O.K."

The views of medical team members with regard to social science attendance at the daily patient management meetings and on the weekly Basin screening trips provide other examples of medical team actions which the social scientists interpreted as attempts to direct the social scientists in their work. All medical personnel believed social scientists should attend both functions. Although the social scientists did attend them in the early stages of their research, they believed further involvement would produce diminishing returns. They wished to remain in their offices where they might attend to their research. Medical personnel continued to request their presence.[17] The nurse practitioners explained that social science attendance was necessary to social science research:

> The things that you're studying are the team. Here we are interacting and sometimes we don't talk to each other but we're saying different things with different means of communication and y'all are supposedly studying the team and here is a good time for you to perceive or report the type of communication. You're wasting it because you all think all we're doing is medical stuff. But there's a lot of other things going on in there.

The social scientists believed they were well aware of the "things" going on in these sessions and were angered by what they considered to be intrusive requests for their

attendance. The anthropologist was adamant in her refusal to attend these meetings, stating that to do so would be a "waste of time." The physician responded:

> It bothers me that she doesn't see anything of interest to her down in the Basin. That bothers the hell out of me because I think the whole day should be interesting to her.

Continued discussion of this matter brought the physician to this angry remark: "Let me tell you that what you have to learn about anthropology and medicine is not there at your desk." Afterward, the anthropologist again attempted to explain the demands of her research schedule:

> Part of what I think you still don't understand about being a social scientist is that for every hour you spend with people, you have to spend another hour at your desk looking at what you've done and deciding what direction to take next.[18]

Another social scientist made this private retort: "You can't goddamn study everything at the same time."

The social scientists came to suspect that clinical team members were trying to tell them "how to do" their work, at least in part, because they did not trust them in their role as program evaluators. This interpretation was heightened by an incident in which a member of the medical team said to the anthropologist, with some drama: "I have a feeling you're part of the intelligencia [sic] around here, the CIA. ESPIONAGE." Another countered most questions with: "Why do you want to know?"[19] The secretary-coordinator explained the medical team's "distrust:"

> They don't like the way you're always asking questions. They say you make too many demands. But I don't really understand that because it was your job to find out about how things worked. I think maybe you just made them uneasy.[20]

When asked what she herself thought of the anthropologist's questions, she continued: "Well, I did get tired of your questions."

Part of the difficulty which the researchers experienced in attempting to define a distinct, research-related role for themselves lay in the high degree of role overlap among all team members. Evidence that each team member was engaged in a wide array of activities is provided in Appendix B. All program personnel, except the public relations consultant, for example, listed themselves as spending time in at least six of the ten categories of program activity listed. In fact, only medical personnel were specializing in any particular activity: that of medical care. Dr. X, the nurse practitioners and the technician-administrator were the only team members who delivered medical care.

Denial of a specialized role for social scientists was further reflected in the listing of research as a job responsibility by every team member except the secretary-coordinator and the two nurse practitioners stationed in the Basin. Yet the amount of research done in the program totalled only nine percent. The vast majority of the

program's time was spent in doing work with a clearly medical focus. If the categories of medical care, social care, travel (to out-patient screening clinics), self-education and teaching are combined, the total is fifty-three percent. Significantly, eleven percent of all program time was categorized as being devoted to social care and every team member except the two part-time members considered themselves to be extenders in this area.

While the social scientists could not practice medicine, medical personnel considered themselves to be practitioners of social science. This is probably the reason why clinical personnel felt free "to tell" the researchers how to carry out their investigations. For the social scientists, this situation was enormously frustrating. As one of them lamented: "What I'm advocating is an intelligent division of labor. We don't have that. I think the social scientists should be allowed to stick to the areas that are their areas of expertise." Since they were encouraged not to follow their job descriptions, the social scientists learned that they could not truly do "whatever they wanted" as the team asserted; rather, they were to do whatever the rest of the team was doing.

In sum, the social science researchers came to believe that social science research was not being accorded the place of respect they felt it deserved within the CHP team.

As one of the social scientists complained: "The medical people don't believe social science is a science." Furthermore, they criticized the program's claim to be a "team" in the contemporary sense of the word. "If you take away social science," a member of the social science subculture noted, "you are left with a model resembling the surgical team." Just as a traditional team uses allied health personnel, the physician sometimes seemed to wish to use social scientists in the same capacity. Social scientists objected to being "used" in such a "low status" fashion:

> Social science is my profession, but with the CHP team I became a paraprofessional. I was to relate to the director as another physician extender except that my speciality was that I listened to tales of woe. I don't like being mozo (servant) to an M.D.

This social scientist went on to draw a picture of the physician as a "mechanic" who sought to "use" social science as he would "a tool, a scalpel, a nurse practitioner."[21] At the same time, the social scientist believed that the physician reserved the right to do anything the social scientists did: "Dr. X believes 'If I wanted to, I could do social science.'"

Summary

This chapter has examined the relationship between subcultural differences and role conflict within the CHP team. By examining the typical day of each subculture, we discovered that members of each were engaged in quite

different work responsibilities. These differences resulted in each subculture's viewing the other in a critical light, a source of conflict which inhibited the development of smooth team relationships. The root of dissension on the CHP team can be traced to the differences in goals and values between the two subcultures. The goals of the clinical team were to provide direct medical and social care to patients and to ensure continued funding for the program. These activities were easily quantified. On the other hand, the social science goals of research and teaching were much more diffuse and difficult to "see," particularly as the social scientists were qualitative researchers. As a result, clinical personnel came to criticize the researchers for spending "too much" time reading and talking.

Behind these differences in goals were primary differences in value orientation between the two subcultures. At their most simple and stereotypical level, these distinctions between subcultural values were described within the program as a dichotomy between medical "doers" and social science "thinkers." Although this polarized concept is unnecessarily rigid, it does reflect the manner in which team members viewed themselves and others and provides a beginning point for a more detailed and subtle examination of subcultural differences.

Having established this background to subcultural differentiation, we examined the two major forms of role conflict which resulted within the team. In both cases, dissension was aroused when the researchers were asked to perform in roles which they considered to be more properly the domain of the clinical team. In the first case, medical personnel requested that social scientists become involved in program funding and social care activities. In the second, the clinical team appeared to encourage public relations work on the part of the researchers while at the same time deemphasizing their research responsibilities. The social scientists were angered in both cases by what they considered to be medical "meddling" in and "disrespect" of their self-chosen role as researchers.

To this point in the study, we have established in detail the existence of the clinical and social science subcultures within the CHP team, of medical dominance, of a corresponding "subsidiary" status for social science and of the repercussions of this situation upon role conflict in the daily operations of the CHP team. Having dealt with factors which are generalizable to all interdisciplinary/interprofessional health care teams, we now turn to a consideration to those items particular only to this particular CHP team: personality and other non-quantifiable factors.

Notes

1. While conflict between the medical and social science subcultures of the CHP team is explained in this chapter as rooted in subcultural differences, it could also be viewed as a paradigmatic dispute. Thomas Kuhn describes competition between segments of the scientific community and the "scientific revolution" which occurs when one scientific theory is rejected in favor of another incompatible with it (1970).

2. The anthropologist constructed this chart at the end of her first research year with the program. All members of the team completed an independent listing of the percentage of work time they spent in each of its categories during the fiscal grant year of 1974-1975. These estimates were collected, collated and then discussed and adjusted in a staff meeting. The percentages thus reflect each team member's individual assessment as well as group consensus.

   If a chart such as this had been drawn up prior to, rather than after, working together team members would have been given the opportunity to clarify their role definitions and to spell out the time-table involved.

3. A great deal of program energy went into funding and public relations efforts. The physician-director, for example, commissioned the production of three slide shows, hired people to work specifically on funding and regularly sent people on out-of-town and out-of-state trips designed to secure funding. As recipients of federal funding, program personnel could not openly admit how much time and energy they devoted to funding activities. The social worker, for example, was forced by the hospital administrator to remove grant seeking as a category in his job description.

4. In stating a preference for "total health care," members of the medical team were unlike many other medical professionals, particularly physicians. For example, during a discussion of the necessity of psychological care as part of medical care, a hospital resident stopped the anthropologist's arguments abruptly with his statement that he "did not care" if his patient killed herself, despondent over a broken limb, immediately after he set the limb.

5. Both the sociologist and anthropologist were involved in short-term quantitative evaluation projects that focused

on non-local aspects of the medical system. They were, however, of short duration and were not a major part of their work activities (see Chapter IV, note 13, for a brief discussion of these projects). Differences between qualitative and quantitative research approaches have been discussed in Chapter III.

It should be noted that this breakdown between the qualitative orientation of the social science subculture and the quantitative approach of the medical subculture is different from the situation usually occurring in mental health settings. There, it is more common for evaluative social scientists to employ quantitative methods and for practitioners to prefer qualitative.

6. Conflict was most intense between the members of subcultures in closest daily association, that is, between the anthropologist and sociologist, and the nurse practitioners. The differences in attitude and behavior were most extreme and expressed most strongly between these two groups. This is not to say that similar attitudes and behaviors were not found among other members of each subculture. Others, however, did not always express them as openly or as vehemently.

7. This same attitude is reflected in the chief of residents' comment with regard to social science classes: "Discussion, yes, but with a solution at the end." The nurse practitioners went further by refusing any discussion at all:

> Talking about it doesn't do any good.
>
> You complicate matters by naming so many alternatives that one can't choose between them.

In doing this, the nurse practitioners were asking to be treated in the same manner as traditional physicians treat their patients. These physicians do not "discuss" the diagnosis with the patient; they "give" it to him.

8. If given written material, the physician often lost it. The head of the hospital's residency program noted the same problem when giving social science articles to the residents: "I don't know what they do with them; perhaps they eat them." The third anthropologist complained that articles given the nurse practitioners for reading could later be found on the floor.

9. Given her overview of program activities, the secretary-coordinator might have made a good team "director."

10. The nurse practitioners may not have liked to read social science, but they did like to read. On one occasion another member of the medical staff grumbled that the nurse practitioners "spend all their spare time in their own room reading."

11. Florence Kluckhohn and Fred Strodtbeck (1961) discuss the use of value orientations as a means of discriminating between cultures.

12. As indicated in the review of the literature, researchers with a social science orientation show greatest interest in defining the problem of team collaboration, while those in the medical sphere concentrate their efforts on solving it. This difference tends to exist generally between academicians and practicing professionals, regardless of whether the practitioners are involved in clinical or in business pursuits. The difference between the "problem-identifying" orientation and the "instant, empirical solution" orientation appears to be a most sensitive area for distinguishing between "head-work" and "hand-work" in the CHP team.

13. Although the physician stated that he "never wanted the anthropologist to do counseling" because he believed he could handle behavioral aspects of cases himself, he nevertheless referred "behavioral cases" to the anthropologist and the sociologist in the social worker's absence. These cases tended to be more complex than the cases he would handle himself.

14. This conceptualization of the patient as being capable of making informed medical decisions, a reflection of the recently popular "self help" movement, runs counter to current trends in medicine. Generally speaking, patients are expected to accept medical diagnoses and regimens. Cancer treatment provides an example. In a recent case in Florida, doctors took a young cancer victim's family to court in an attempt to force them to follow the medically-prescribed regimen of chemotherapy rather than their self-prescribed regimen of Laetril. The family fled to Mexico.

15. This social scientist further stated: "I don't think you can be a good social scientist and go out and be a program advocate at the same time." He was supported in this perception by the first anthropologist who reported that while operating as a fund-raiser for the CHP team he found himself "writing things that were not true." He

had, in his own words, "lost" his "objectivity as a social scientist."

16. One of the nurse practitioners published just such an article in a state-level nurse practitioner magazine. Although the physician was upset that the article had not been submitted to him for review, he was so pleased that he gave the nurse practitioner a monetary bonus. The article was published under the names of all the program nurse practitioners, rather than that of its single author.

17. Conflict in this area might never have occurred if the correspondence between the social science daily "time-table" and the medical subculture's "direct patient care encounters, charting and billing schedule" had been made clear prior to beginning teamwork activities.

18. Some social scientists argue that every hour spent "in the field" requires at least two hours "at the desk."

19. Even the program's third anthropologist proved distrustful as a research subject. On one occasion, the anthropologist was discussing program business with him and a member of the medical subculture. The third anthropologist broke in: "Be careful what you say in front of her. Don't you know she writes it all down?" The anthropologist was astounded at being undercut in this manner, particularly by another social scientist. When she later asked the third anthropologist why he had done this, he apologized for "taking a cheap shot" at her in order to improve his own standing within the team. His statement seemed to indicate that he too felt intimidated and distrustful when faced with evaluation.

20. At a point toward the end of the first year of research one of the nurse practitioners was remembering how "glad" he had been when the curtains were removed from around the social scientists' desks (these curtains of "La Batalla de las Cortinas" were only very briefly in place, see Chapter 4, footnote 5). He stated that he "had heard" that the social scientists had been "practicing behavior-mod" behind those curtains. When pressed for details, it became apparent that although he did not know exactly what behavior modification was he believed it to be something awful.

21. This feeling of being a paraprofessional, or assistant to the physician, was reinforced when the social scientists were asked to ensure patient cooperation. It then ap-

eared to the social scientists that medical personnel intended to use them to make life more comfortable for themselves by having the social scientists handle the unpleasant or difficult cases. The following statements made by social scientists demonstrate this interpretation:

> The social scientists are being asked to handle the unpleasant cases.
>
> The social scientists are to make the rest of the program more comfortable for the medical personnel.
>
> The physician's only understanding of social scientists is that they're someone you call on when you have problems.

CHAPTER VII
THE IMPACT OF PERSONALITY, GENDER, ETHNICITY AND SOCIAL CLASS ON THE CHP TEAM

While the dominance of one team subculture over another might be expected on an interdisciplinary/interprofessional team, the factors of personality, gender, ethnicity and social class will vary from team to team and are not as predictable. The elements discussed in this chapter, therefore, stand as complicating factors which add to the stress already present between the team subcultures. Based on my observations, I concluded that they are not determining factors precisely because they do differ significantly from team to team. To generalize, their effect was to compound the difficulties in role definition already occurring as the natural result of team subcultures in a setting of medical dominance.

Examination of the influence of personality, gender, ethnicity and social class upon the functioning of the CHP team is relevant because it allows us to analyze their secondary impact upon the issues of cooperation and conflict resolution as played out in the particular setting of the CHP team. By focusing on elements specific to the CHP team, we are assessing the impact of variables less important than, yet still important to, our fundamental emphasis on

team subcultures in a setting of medical dominance. These factors are examined here to acknowledge, but not to exaggerate, their importance.

Taken together, the factors discussed in this chapter constitute the manner in which team members chose to manage their "presentation of self"[1] to other team members and to the world at large. The term "presentation of self" will be used here to refer to how team members defined their work behavior. It is a form of impression management. The idiosyncratic manner in which team members chose to present themselves within the CHP team functioned to exaggerate the already existing split between the social science and medical subcultures. In a setting in which the structural reality of separate subcultures was already so profound, further splits along lines of personality, gender, ethnicity and social class made problems of collaboration much more difficult than they otherwise would have been.

Personality

While the structure of medical dominance creates collaborative problems for social science researchers in an interdisciplinary/interprofessional team, the exact form of these difficulties will be peculiar to individual teams. Generally speaking, medical members of the CHP team were not "friendly" toward the researchers. This in itself had little to do with the personalities of individual team members,

although the team members themselves often blamed conflict within the team upon the "defective" personalities of members of the other subculture. Although this was a distorted point of view, personality, or more aptly presentation of self, did have some impact upon team functioning. The effect of personality, however, operated within the context of the already existing situation of subcultures in a setting of medical dominance. We find, for example, that the personality of certain medical team members had a greater impact than that of other team members precisely because of their status as members of the dominant subculture.

The Blaming of CHP Team Conflict Upon Individual Personality

Conflict in American society is often attributed to problems of individual personality, an assumption that in many cases is incorrect. Dissension within teams, for example, is often related in large part to the group's structure and not to the personality of its individual members. Personality clashes between team members, for example, are often concomitant to or aggravated by organizational factors (Peeples and Francis 1968; Rodman and Kolodny 1971; Rubin and Beckhard 1972). When such conflicts occur, individuals may discover they have been labeled as defective personalities, particularly if they work against established team practices (Rodman and Kolodny 1971).

Within the CHP team, problems of team cooperation were often blamed on individual personality. Every team member, including all of the social scientists, believed at least in part that what was "wrong" with the team was the individual personality of some of its members. Clearly, this was a problem of attribution since, by focusing on personality, team members were ascribing negative personality characteristics to all members of the opposite subculture. A few team members, notably the physician and the social scientists, moved beyond personality to an appreciation of the structural difficulties occasioned when members of disparate disciplines and professions attempted to work under the "same roof." No one, however, analyzed the team in terms of subcultures.

Accusations of personal shortcomings were directed across subcultures[2] but were never directly stated to the person so-targeted. Members of a particular subculture, moreover, usually did not complain on the same scale about the personality of team members from their own subculture. We have, for example, the following complaints lodged by medical staff about the social scientists:

He has ego problems that border on ill health.

He has ego conflicts.

He's playing personal games.

He's a sick, emotionally unstable person.

He has behavioral problems and a destructive personality.

Conversely, social scientists made similar statements about the personalities of medical personnel:

He has personality problems.

He has a fragile ego.

He's a well-motivated sickie.

He's off the deep end mentally.

Team members made these attacks on the character of members of the other subculture whenever they were upset with that person's behavior or attitudes. The preceding three chapters have detailed the patterned behavioral differences between subcultures and the friction occasioned when members of one subculture faced behavior or attitudes different from their own.

While misunderstanding of organizational constraints can lead to misdirected attacks on personality, interpersonal relationships[3] and individual personality do have an impact on team performance (Rodman and Kolodny 1971). In the case of the CHP, the personality of the physician, as program director, had more of an impact upon team operations than that of any other team member. His attitudes toward the pace of work and toward administration, for example, had a pronounced effect on the work atmosphere of the CHP team.

The Physician-Director

The personality which the doctor was perceived as presenting while at work was that of an extremely hard-working and busy physician who did not take time off, even for illness. As program director, for example, Dr. X spent nearly every waking hour at the Seaside Hospital or on program trips to outpatient screening clinics. In reference to his high level of activity,[4] one medical team member noted: "Dr. X has so many things going, I don't see how he does it. When I first came here I thought, 'My gosh, he's going to kill himself going at such a pace!'" Dr. X also displayed a high level of emotional investment in the CHP. A social scientist noted: "It's his baby, it's his toy. It's serious, but in a way it's like a yacht too. It's his avocation and his vocation. He loves it."

Dr. X would have preferred that all team members be as involved as he. He considered program membership to entail a "seven day a week" commitment: "When you are in this field you have to put in these kind of hours whether you are a nurse, a doctor, or a social scientist." And again:

> Saturday is a work day for all of us. I really despise the idea in a health care team that Saturday and Sunday are days off. Goddamn it they're not, they're work days. I'd like to see some of these people come in on Saturdays.

Although team members spent many, many hours at work, however, no one was ever able to match the extra hours Dr. X

put in making rounds at night and on weekends, teaching early morning classes to the residents, dictating patient files, and so on. Medical staff members felt the strain of this demanding work routine:

> You have to have good health to keep up with this team. Our hours are long and grueling. It's not just an 8-5 job. You have to stay late at night sometimes and come in on the weekends too.

And, as yet another member of the medical subculture noted: "Everyone hustles here. You can't help but work hard in this program."

Dr. X was so involved in work that he did not remain at home even when ill. In his opinion those who stayed at home when ill were "sissies." Illness, consequently, was not considered sufficient excuse to be absent from team activities. A member of the medical staff noted: "You shouldn't stay home unless you have documented proof that you are close to dying." The detailed discussion which ensued revealed that one might safely remain at home only when incapacitated by vomiting. As one of the nurse practitioners declared: "When I'm sick, I'm at work."

Dr. X's personal stand on work ethic contributed to considerable tension within the team, as team members struggled to keep pace with him. This pressure for commitment of large amounts of time left some medical team members feeling exhausted and several complained of its toll on their personal life. One of the nurse practitioners reported:

"That's why I'm leaving the program, because you have to spend too much time working around here. Man, it's just too much and it's ruining my family life." Under such conditions, some staff members felt they were being forced to choose between their careers and their family life. One member of the team hypothesized that this conflict was at the root of the departure from the team of the two female nurses hired during the team's early days.

Another major influence upon team productivity occurred when Dr. X, as team leader, decided to organize the team along multileadership lines. He stated: "I would like to see multileadership roles in this program," using the analogy of sending many hunters into a single field to further illustrate his meaning. Dr. X believed that the more people involved in a project, all headed in different directions, the more likelihood of success:

> With the shotgun approach I felt we were most likely to succeed. Each person has certain talents and one person's talents compliment those of another. This makes the program stronger.

He held the philosophy that job descriptions were "created for idiots." Although each team member had a written job description, these were used only to satisfy the hospital administrator and outside funding sources. With the program these descriptions were largely ignored.

The resultant role overlap caused a high degree of role conflict among team members,[5] as was discussed in Chapter

VI. As a member of the medical team pointed out: "I think our first problem was that we did not know who was to do what, or who would be in charge of whom." This uncertainty bred aggressive conduct. The same nurse practitioner explained why "it's not easy to work on this team:"

> You've got all these people and no one wants to be another dog. Everybody wants to be superdog. Everybody has their own special deal, this vast amount of knowledge that nobody else has got. There are all these people here who are ready to shoot. Somebody might come up to you at any moment and really put it to you. They might not be exactly up on what they're talking about but they can really give you hell about it.[6]

The Physician and the Nurse Practitioner "Sub-Chief"

The physician's presentation of personality also affected the team because of his decision to use one of the nurse practitioners as his informal "sub-chief." The nurse practitioner selected by Dr. X was the most senior of the nurses, having been with the program several months longer than any of the rest. In this role the chosen nurse practitioner assumed the position of supervisor of the nurse practitioners and the title of "'chief' nurse practitioner." He was serious in his assumption of authority. As a member of the medical subculture noted: "He feels like he's number two, next to Dr. X." On one occasion, for example, he scolded the anthropologist for not asking his opinion earlier on program issues:

> Professionally, you're not giving me any respect. I'm supposed to be head of this, head of that, head of this, and head of that. I'm the head of everything and I feel like a head of lettuce sometimes.

In his self-designated position of "second-in-command," the chief nurse practitioner seemed to act as a policing and punishing agent for the physician. He explained this role:

> I'm not the one that always goes out and chews people up just because I want to. It's because I've been put up to it. It's not always me. I'm an instrument, just like the rest of you.

Continuing, he defended his position:

> I don't have time to talk to people in private because I'm used by Dr. X to go out and chop people down or change what they're going after. I do it in public for a reason, so that maybe you don't want to be at the end of whatever hell it is I'm delivering the next time. If I went in a private room every time I wanted to cut somebody down, I'd be in a private room all the time.

As his statements imply, the chief nurse practitioner did not always wait for orders from the physician before acting. As one of the social scientists pointed out, he often used his "own initiative" to decide when things needed to be "taken care of" and sometimes "harrassed" team members on non-work-related issues. A member of the medical subculture concurred: "He baits people. He plays that goddamn game all the time. He has to prove he's a big man." There was no member of the entire team who did not consider the chief nurse practitioner to be a difficult individual with whom to work. As another member of the medical subculture

declared: "He hurts people violently, not physically, but psychologically."[7]

The sub-chief's behavior was thus not just a variation on the theme of clinical versus research conflict, but was actually a personal signature in relationship to the team as a whole. Some authors suggest that there may be a certain type of "rigid" personality that will never adjust successfully to a team situation (Eaton 1951; Richards 1970). Such a person might be an extreme individualist, not an uncommon personality type in American society. Operating with only his own concerns in mind, a highly individualistic person might find himself unable to subordinate his personal needs sufficiently to ensure achievement of the larger group's goals. The chief nurse practitioner may have been such a person.

At the same time, however, the actions of the sub-chief were also a reflection of general medical, or more specifically, physician dominance, in that he was selected by the physician to act in a specialized role of some responsibility.

The physician was cognizant of the manner in which the chief nurse practitioner's personality affected team operations. In discussing this, he noted:

> I think the chief nurse practitioner is probably teetering on behaving in ways that don't benefit

> everyone, by approaching problems in a militaristic, or militant, physical, or less productive manner.

Dr. X also linked the behavior of the chief nurse practitioner and that of the rest of the nurse practitioners:

> I think some of the nurse practitioners' attitudes may have teetered on being destructive. Their approach, their goals, could have been more efficient and meaningful.

In spite of his awareness, the physician took no action in his role as team leader to halt their behavior. When the anthropologist approached him at one point about difficulties in coordinating a program project on patient education with the chief nurse practitioner, the physician advised her to do as he himself did: "Just make him feel like a big wheel and he won't give you any more trouble."

Despite his criticisms, the physician allowed the subchief to continue his "enforcer" role perhaps because in his eyes it appeared to serve a useful purpose. The chief nurse practitioner himself suggested that purpose:

> Dr. X manipulates me to manipulate other people, including you, including the sociologist, including everybody, because he wants everyone to like him. So I'm the one no one likes and it doesn't make any difference to me. In every organization there's always someone who's not loved by anyone and I'm the one here. Dr. X will use other people but I'm the main one. I'm the one that knows everything about everyone because he tells me. I'm two people, I'm part him and I'm part me and in a way I like it and in a way I don't.

The physician's rationale in organizing the team in this manner was possibly best illustrated in the statement he made to the anthropologist following his discussion of the nurse practitioners' attitude: "I think perhaps they keep you (the social scientists) honest." Dr. X's use of the sub-chief in an administrative capacity may reflect his own lack of interest, particularly in supervising individual work performance. Referring to his relationship with the first anthropologist, for example, he stated:

> Many of the problems with the first anthropologist were the result of my own administrative inexperience. I didn't have the competence to supervise him and I didn't even really want to be a supervisor.

Given this situation, one of the social scientists hypothesized that Dr. X used the nurse practitioners to "control" members of the social science subculture:

> Dr. X uses the nurse practitioners to control the social scientists, to keep them in their place. He wants everyone below him to be in a fighting state of disarray.

Whether he was attempting to "control" team members or merely hoping to instill a spirit of competition, the effect of Dr. X's administrative approach was to actively promote dissension within the team. Moreover, he believed this was good for the team, declaring: "Conflict is great; it's a very positive thing." He even went so far as to argue that the team could not survive without it:

> I seriously wonder if the program will die when it becomes all pleasant and so unnatural. I think many of the good things of our lives have been extemely traumatic. Of the advancements I have made, the most satisfying have been extremely traumatic.[8]

By encouraging conflict between team members,[9] however, the physician complicated and contributed considerably to the development of role conflict between the two subcultures.

In summary, it is clear that the physician was the only team member whose personality had a major impact on the structure of team operations. This was the result of medical dominance: Dr. X was the key member of the team. Thus his presentation of self had more impact than, say, that of the sociologist or anthropologist, or even of the individual nurse practitioners. The chief nurse practitioner's method of communicating with fellow team members also affected the team in significant ways, but only because the physician gave him a special administrative role.

By selecting this particular nurse practitioner to act as administrative assistant, it is possible that the doctor was responding to the nurse practitioner's willingness to engage in such activities. However, it also appeared to the social scientists that he was encouraging team members to fight rather than to cooperate with one another. The CHP team, then, did not embody a spirit of cooperation. In general, this approach to administration tended to exacerbate, rather than eliminate, conflict between the medical

and social science subcultures. Finally, the physician's attitude toward work pace also generated tension. In expecting team members to behave as he did, Dr. X created unnecessarily severe demands on the CHP staff. The result of these combined factors was a generally strained atmosphere.

Gender

As with "personality" impression management, CHP team members were also concerned with managing "gender" impressions. That the two are related is demonstrated by the fact that within the program medical behavior was defined as being "male:" medical men were aggressive, hardworking and stoic. These and other ideas regarding sex-related behavior were prevalent within the team and provide excellent documentation of the role gender plays in affecting the manner in which team members choose to present themselves and choose to perceive the presentation of others. As with ideas concerning proper medical "personality," the stereotypical ideas which some male team members held toward their female co-workers also complicated the development of team cooperation.[10]

Females were a minority within the team, as eight of the twelve team members were male. In addition to the anthropologist, there were three other female team members: a nurse practitioner, still in training, and the secretary-

coordinator and the technician-administrator, both of whom held clerical positions with minor administrative responsibilities. The anthropologist, then, was the only female team member to hold a "professional," or non-technical, non-clerical, non-apprenticeship, position within the program. At least one other female team member was also aware of this situation:

> I look at the position of females in this program and I resent the fact that females are the ones who do all the work that is repetitive and very time-consuming. There's no glory in it, although the program couldn't operate without it, and there's no recognition for their efforts.

Generally speaking, male team members seemed to define themselves in opposition to women: for example, if men are hardworking and stoic, then women are less "reliable" and more easily "rattled." One female team member complained of this attitude:

> Being female, you have to try so much harder to show people around here that you're able to do something. They seem to think you're inefficient. It's not a fair attitude.

Of all team members, the male social scientists seemed to hold less firmly to such attitudes regarding the ability of women. Although they demonstrated more surface sophistication and could be heard speaking tolerantly of feminism, however, they too made distinctions based on gender. The third anthropologist, for example, once stated:

> I treat women differently from men, there is no question about that. I do it because they are different. I know you're a person, but there are things about males and things about females that are different.

Similarly, the sociologist once complimented the anthropologist on managing to have a career and yet maintain her "femininity," seeming to imply that most career women were masculine and that that was something women should avoid at all costs.

The members of the medical subculture seemed to define themselves most sharply in contradistinction to women, and their attitudes had a more powerful impact upon their working relationships with female team members. Among the medical group, only the physician demonstrated any awareness of this issue as a factor in team operations. In response to a question from the anthropologist as to why he called only the sociologist at home to discuss program matters, he replied:

> It's more difficult for me to call you up as a woman. It's not that it's you. I just always have not been able to talk to women very easily. Just to be honest with you, I feel much more comfortable calling the sociologist up on his farm. It doesn't mean I like him more than I like you; in fact I like you more than him.[11]

At the same time, Dr. X could reveal stereotypical ideas regarding women. He once paid the anthropologist what he obviously intended as a strong compliment, saying: "I really respect you, especially as a woman." He was probably

unaware that he might be perceived as implying that women were not usually deserving of respect.

The nurse practitioners seemed to hold most strongly to the idea that women were not only different from, but actually inferior to, men.[12] Their attitudes toward women permeated their work and were readily apparent to women outside the program. A visiting nurse once questioned the nurse practitioners: "You guys are always putting women down. What's wrong, don't you like women?" The nurse practitioners responded: "Oh no! You've got it all wrong; we love women." On another occasion one of the male nurse practitioners told the female nurse practitioner in training to "talk like a nurse practitioner, not like a woman," apparently overlooking the fact that very few nurse practitioners are male. He appeared to female team members to believe that nurse practitioners had to be male in order to be CHP team nurse practitioners and that there was something wrong with talking "like a woman."

This notion that women were inferior to men had a general impact upon program operations. Because women were viewed as not as capable of work as men, they were not hired as frequently and, when hired, were treated with less respect. Male team members were in the process of modifying their attitude toward hiring women during the second anthropologist's tenure. It was during this time that the

physician responded to an inquiry from an outside consultant as to why only one of the four nurse practitioners was female by stating:

> We may have made a mistake in the past by assuming that women were not cut out for the position of nurse practitioner in this program. We thought women were too unstable and two female nurses had to leave the program because of behavioral problems.

Two of the original nurse practitioners in the program were females and one was male. The two females left the program within the first year of its operation. At this point, the remaining male Mexican American nurse practitioner began to recruit other male, Mexican American nurses. This explains the unusual bias within the team toward male nurses. While only 0.1 percent of registered nurses in the United States in 1970 were male Hispanics (Alvarado 1980), 75 percent of the CHP nurses were male.

The chief nurse practitioner stood by his original opinion about female nurse practitioners: "A guy can handle the nurse practitioner job in this program better than a girl. Girls can't withstand the pressure." He also felt that the program needed a male social worker because "women cannot counsel men:"

> The health decisions in the Mexican American family are made by the man; he is the head of the family. A man will not discuss these issues with a woman because he will not be able to reveal his innermost fears and anxieties to her.

The male nurse practitioners' idea that women could not work well with Mexican men extended also to the activity of teaching. When the anthropologist had occasion to teach a social science class for the nurse practitioners without the company of the male sociologist, they responded by being unruly and disrespectful. Another female team member attempted an explanation of this behavior: "I don't know that the nurse practitioners can be taught by a female. They are male, real, real, male. Their attitude is 'You're female, now how can you teach me something?'" She elaborated further predicting continued difficulties: "It's because you are, one, a woman; two, have a degree; and, three, are an Anglo. Those are the three strikes against you with the nurse practitioners." A Mexican American consultant to the team also interpreted the situation in terms of sex-related behavior, pointing out that the anthropologist was deviating from traditional roles: "Those guys are macho, machos. It's part of their culture. They want a nice old Mexican American woman and you can't be that."[13]

As a female member of the team, the anthropologist did not play the role of a traditional female. She retained her maiden name after marriage, did not defer to male team members and freely gave and argued for her opinions on program matters. Her personality, although somewhat shy, was not demure. The nurse practitioners were aware of this

discrepancy between traditional female behavior and the role chosen by the anthropologist, as the following statement indicates: "If we asked you to type you would say no, I'm too busy on my project and besides I don't do womanly things except . . ." As his words indicate, this particular nurse practitioner had asked the anthropologist to type things for him, a request she refused.

The anthropologist found it difficult to maintain a working relationship with the nurse practitioners because of their attitudes toward women. In addition to the examples cited above, the nurse practitioners would occasionally refuse serious conversation with her and turn her attempts to talk about program business into sexual innuendo. On one occasion, one of the nurse practitioners persisted in pretending that he was going to burn her with his cigarette lighter while she was trying to discuss program business. When applicants were discussed for the position of third anthropologist, both nurse practitioners made sexist comments regarding female applicants such as these:

> "What are the vital stats of the new anthropologist?"
>
> "Her age and her measurements?"
>
> "If she looks like you, we'll take two."[14]

The nurse practitioners' difficulty in maintaining a consistently professional relationship with the anthropologist seemed to lie in their discomfort in dealing with women as

peers. As a male Mexican American consultant to the program noted: "They just cannot imagine having an adult-to-adult relationship with a woman. They always imagine there is some sexual thing to it."

In sum, within the CHP team, at best women were being treated differently than men and at worst being assumed to be less competent than men. In her role as a professional woman with academic degrees, the anthropologist suffered more than other female team members in being stereotyped by men. This was in part because she did not operate in the more traditional role of nurse or clerical worker and was therefore in a more central position. Since the anthropologist was also the youngest team member, age tended to be an additional complicating factor in firmly establishing the already secondary status she held as a member of the social science subculture.

Ethnicity

Since consciousness of ethnic identity was ever-present on the CHP team, ethnicity was a factor which also influenced team collaboration. Composed of Anglos and Mexican Americans,[15] the CHP team sometimes had to deal with problems associated with some team members' tendency to allow consciousness of being or not being Mexican American to affect their work. While ethnic identity was not a major influence on team operations, it did interfere at times with

the ability of team members to work together smoothly by exacerbating the difficulties already occurring in role definition.

Anglo team members included the physician, sociologist, anthropologist, economist and technician-administrator. The Mexican American section was composed of the secretary-coordinator, the four nurse practitioners, the social worker and the public relations consultant.[16] It should be noted that all of the social scientists were Anglo and that the two members of the medical subculture who were Anglo, the physician and the technician-administrator, were the founding members of the CHP. The doctor had applied for and received funding to finance the CHP team when he was a private practitioner and the technician-administrator his assistant.

Mexican American team members described themselves as being either Mexican American or "Chicano." Three of the nurse practitioners, the social worker and the public relations consultant all referred to themselves as Chicano.[17] When Mexican American team members called themselves Chicano, they were making an ideological distinction between themselves and other Mexican American members of the team.[18] In essence, Chicanos defined themselves as being politically aware of their ethnic identity and as being politically active in an effort to protect or promote this identity.

Mexican Americans were regarded as those who wished to assimilate into the dominant Anglo culture. Chicanos, however, saw themselves as attempting to maintain their ethnic identity and to advance their status as an ethnic group. In the words of one Chicano team member, Chicanos were individuals "with political influence" with whom "Mexican Americans or Latin Americans did not necessarily identify."[19] Chicanos were seen by this team member as banding together, as "brothers to one another."[20]

All Chicano team members were extremely aware of their cultural identification. They often discussed the "difference" between Anglos and Chicanos, demonstrating their perception of themselves as victims of discrimination.[21] One Chicano team member spoke with some emotion of his feeling of being an outsider in Anglo society:

> I don't expect to be accepted in Anglo society. I can tell when I'm in the airport on a funding trip and people look at me funny. When I'm in Washington or San Francisco, they think: "There's a Mexican American. What's he doing on this plane?" Don't you think I look around the plane to see if anyone else has the same skin color? You don't because you know there are Anglos. On the other hand, very few Mexican Americans ever travel by plane.[22]

This feeling of discrimination was corroborated by the hierarchical structure within the CHP itself. The Chicanos and Mexican Americans in the program tended to have the least academic training and to hold subordinate positions. As one Anglo team member noted in sympathetic explanation of

the Chicano's anger: "Just look at the people who are teachers and leaders in this program; they're all well-educated and they're all Anglo."

One of the Mexican American team members also spoke of the anger of the Chicanos:

> I just don't know about those guys. They are so prejudiced. They are just about the most prejudiced people I know. We had this conversation:
> "Why do you treat people like that?"
> "Others have done it to us."
> "Yes, but these are different people."

Within the program, it was common to hear overt expressions of "reactive racism"[23] by the Chicanos. "I am racist," boldly stated one Chicano member of the team. Similar statements included:

> "Anglos can do it, but Mexican Americans can do it better."
>
> "If it's Anglo, I don't want any."
>
> "Some of my best friends are Anglo."
>
> "He's the only Anglo I ever liked right from the first."
>
> "He's not bad for being an Anglo."[24]

One Chicano went as far as to state that he would "never sleep with an Anglo female," a position interpreted by Anglo male social science team members as being the ultimate in racism.[25] This same team member, however, defended himself against the charge that he was a racist: "They always say

I'm a 'Super-Chicano.' That's not true. I never maliciously cut someone down just because he is Anglo."

When confronted by Anglo team members about their ethnic resentment, the Chicanos defended themselves with justifications such as these:

"We have to take care of our own first."

"Anglos have always discriminated against us and now we're discriminating against them."

"I have a right to be biased. I'm human."

In search of political and ethnic identification as Chicanos, the two Chicano nurse practitioners with Anglo names hispanicized them (for example, from Edward to Eduardo). The Chicanos also spoke in "Nex-Mex," the regional colloquial Spanish dialect. The pride which they took in having a separate language can be seen in the Chicano social worker's habit of lacing his English with Spanish phrases such as "este" (this), "entonces" (then), "también" (also), and "pero" (but). He spoke this way in mixed groups of Anglos, Mexican Americans and Chicanos. Yet another example of ethnic pride was demonstrated in a request by a Chicano nurse practitioner for brown stationery: "I'm brown and I want everything I use to be brown."

Action taken by Mexican Americans, as Chicanos, to emphasize their ethnic heritage are of recent origin. Chicano team members came from families whose parents had

emphasized assimilation. They gave their children Americanized names and encouraged them to speak English. A generation later, as adults, these same children rejected an assimilationist approach, choosing instead to band together politically as Chicanos. Their goal was to emphasize and glorify their ethnic heritage.

The goal of both generations of Mexican Americans has been to gain status and power. Each generation has pursued the same political goal throuh differing strategies of adaptation. First-generation Mexican Americans attempted to secure a position in American society by adopting American ways. Many of the children of Mexican Americans for whom this strategy was unsuccessful--the sons and daughters of working class Mexican Americans who felt they and their parents had been denied full participation in Anglo society--then responded politically by organizing as "Chicanos."[26]

One impact of Chicano reactive racism upon the team was that the social scientists encountered substantial difficulty in attempting to deliver or relate a cross-cultural understanding of health care to radicalized Chicano team members. The Chicano nurse practitioners, for example, refused to admit or to discuss differences between American and Mexican American culture which they perceived as negative. Discussion of expressive bereavement rituals or

patterns of alcohol consumption were met with denials that there was any distinction at all. Chicano team members held that apparent "differences" were due to individual behavior, thus denying the utility of social science knowledge of Mexican American culture. In taking such a stance, they refused further discussion. For example:

> Well, how can this be related to ethnic background when others who aren't Mexican American do the same thing? It doesn't say anything about my culture; it's just individuals.

The one exception to this pattern of denial occurred whenever the cultural differences being discussed were seen as desirable. When Mexican American folk medicine was discussed as efficacious, for example, Chicano nurse practitioners would describe the folk medicine practices of their immediate family members in detail.

In denying cultural differences, the Chicanos also stated that Anglo social scientists had no knowledge of Mexican American culture:

> I don't think you know what you're talking about when you talk about the Mexican American. Studies by noted anthropologists and sociologists have been disputed by Chicanos and I side with the disputers. I don't think you understand the Chicano culture. Maybe you have to be part of it to understand.[27]

Who did know about Mexican American culture? Chicanos: "I know these people; they're my people."[28] The Chicano belief was that, as insiders, they were the only ones who could understand: "What can somebody tell me that I really don't

know? I've been on the inside. You're an outsider and you can't tell me what is going on inside."[29] How did they know "all about it?" As one Chicano team member stated in explaining why he had no need for social science: "Your education starts as a kid; you pick it up as time goes by."

When questioned directly about whether team members needed to be Mexican American (or, more precisely, Chicano) to be accepted by Chicano team members, one Chicano team member suggested the answer to be yes: "I'm not sure, but I think that you may." Another was more direct: "Frankly, yes. You have to be Chicano to be accepted by us." He went on to explain the reasoning behind his statement: "When you are Chicano, there's a common bond there right off the bat. We know what the problems are, we're brothers, and it really does help communication a lot."[30]

Yet another impact of Chicano reactive racism upon the team was the tendency of the Chicanos to openly favor other Chicano team members. In referring to the social worker, for example, a nurse practitioner noted: "I think that one reason the social worker doesn't have any problems with us or we have any problems with him is because he's Chicano. He's not Mexican American." In recognition of this bias, one Anglo team member was moved to this frustrated complaint: "If an Anglo does it, it's shitty. If a Mexican American does the same thing, it's wonderful."[31]

As was discussed in Chapter V, the social scientists had a secondary status as members of the team. Their position as Anglos contributed to the feeling of distrust and disregard which Chicano team members already felt toward them as social scientists. Ethnic resentment toward Anglos was thus a complicating and not a determining factor in retarding team cooperation. This becomes readily apparent when we realize that Chicano team members did not discriminate against the Anglo physician team leader. The physician himself was aware of this disparity and noted in reference to his freedom from racial harrassment: "I have a lot more to negotiate with in dealing with the nurse practitioners than you do as an Anglo."

Social Class

It is somewhat difficult to separate social class from ethnicity in the CHP team, since Mexican American team members tended to come from working class families and Anglo team members from middle or upper middle class backgrounds. Dr. X, the son of a local working class family, provided a notable exception to this pattern, thereby complicating the usual association. In marked contrast to ethnicity, team members did not usually express an acute awareness of social class or its influence on team operations. Still, class-based attitudes clearly affected some interactions among

team members by complicating the development of effective team collaboration.

Awareness of economic background and status had some impact upon team cooperation, particularly between the Mexican Americans, the sociologist and the first anthropologist. Some of the nurse practitioners came from very poor backgrounds. One was born into a family of eighteen children which migrated, during his younger years, in search of seasonal farmwork.[32] Another reported: "My family had nothing. My father worked and he drank. What he didn't drink up he gave to my mother once a week and she tried to feed us." In holding stable positions and earning a good salary, the nurse practitioners were interested in material possessions as proof of their success. One Mexican American nurse, for example, was very proud of owning two digital watches, "one for 'good' and the other for 'every day.'" This same individual reported going into one of the most expensive shoe stores on Fifth Avenue during a program funding trip to New York: "I went into that store and tried on their shoes. I didn't buy but I did try them on."

By contrast, the sociologist was from a wealthy South City family with oil holdings. Some team members felt resentful about his privileged background. A medical team member of working class background once stated angrily:

"The sociologist, he's a rich boy. I don't want to hear his opinions about how this program is spending its money."

The impact of class upon team performance can be most clearly noted in the team's perception of the first anthropologist as being more privileged than they. The general medical view of the first anthropologist was displayed in the following summary offered by a member of the medical team:

> The gentleman came aboard and kind of intruded and didn't yield to being accepted in our subculture. An academic easterner that came all dressed up and then sat and watched us with belittling eyes.

A somewhat more sympathetic description was provided by yet another member of the medical team:

> The first anthropologist didn't relate to team members on a warm, personal basis. That's not his nature. He much preferred to be in an academic setting. He just didn't get any stimulation from the nurse practitioners. He didn't adjust well to a non-academic setting.

All members of the social science subculture agreed that the first anthropologist was "an academic elitist" and "very proud of his northeastern upbringing and schooling." They did not, however, feel "looked down upon" as medical personnel seemed to, perhaps because they were members of the first anthropologist's subculture.

Medical team members in general and the nurse practitioners in particular seemed to resent the manner in which they felt the first anthropologist considered himself to be

"better than" they as a consequence of his affiliation with the upper class. The first anthropologist attempted to explain this phenomenon: "They're angry with us for being more wealthy, more powerful, for being more whimsical and inconstant, for blowing hot and cold." A member of the local medical establishment also came to a similar interpretation when he suggested of the nurse practitioners: "They come from poor families and all their lives they wanted to be big shots and now they utilize their positions for that and nothing more."

These quotations reflect what appeared to some to be an almost obsessive concern with equality on the part of the nurse practitioners. Such an attitude seems to indicate their perception of themselves as being, at worst, unequal to others or as being, at best, in danger of losing their equality. Behaviorally, the nurse practitioners might be most aptly described as having a chip on their collective shoulders. As a fellow medical team member noted: "The nurse practitioners feel like they are equal to anybody." This statement implies that the nurse practitioners did not feel naturally equal and felt the need to claim equality as their right. This attitude was apparent in statements regarding work. As one nurse practitioner argued: "You have to work here with people of all different kinds of educational background but that doesn't mean one person is more

important than the rest." Another nurse practitioner described someone he considered to be particularly agreeable: "He doesn't think he's above us or below us; he's just there."

Feelings of class antagonism or resentment within the program were most strongly expressed toward the first anthropologist and, later, somewhat less strongly toward the new Anglo social scientists. Class resentment seemed to operate within the CHP team in a fashion similar to ethnic resentment. For example, many physicians, because they are drawn largely from upper class families, might display similar class-linked attitudes. It might be conjectured that such attitudes would have been tolerated within the program if the first anthropologist had been a physician.[33] Instead, certain attitudes and behaviors of the first anthropologist which might have been easily tolerated and possibly even expected within the confines of the stereotypical "ivory tower," the more traditional setting for anthropologists, proved to be "the kiss of death"[34] within the team.

Summary

Differences in personality, gender, ethnicity and social class had a perceptible influence on the operation of the CHP team. While these distinctions were not of major importance to team operations, they were significant, and, at times, an impediment to the development of cooperative

relationships. The precise impact of such factors as personality, gender, ethnicity and social class cannot be predicted, but the distribution of power on any interdisciplinary/interprofessional team offers a clue to their potential influence. In the case of the CHP team, medical dominance provided a structural "advantage" to the operation of those characteristics held by members of the medical subculture. Restated, it is evident that the personal characteristics of a member of the dominant medical subculture would have, and did have, a greater impact on team operations than those of a member of the social science subculture.

In the case of the CHP team, the physician's "personality," or presentation of self, had the strongest impact of any team member. Playing the role of "hard-working" physician and team leader, the doctor expected other team members to become equally involved in program activities. As team leader, Dr. X also assumed an aggressive stance with relationship to other team members. Because the "sub-chief" identified with the physician "chief," he tended to act as a sorcerer's apprentice in aggressively assuming the doctor's place. As a result, competition and tension within the team tended to increase.

The interrelationship among personality, gender, ethnicity and social class can be amazingly complex. On the CHP team, for example, the goals of hard work and competition so

strongly expressed by Dr. X are traditionally masculine, rather than feminine. There was also a strong link between ethnicity and class within the team as most of the Mexican American members of the team were of working class background. That this relates back to the issue of personality and gender becomes clear when we realize that most of the Mexican Americans were male members of the medical team. It is apparent that these associations tended to magnify the dominance of the medical over the social science subculture.

Although complex, these factors are real and exist on any team as complicating elements in team collaboration. Their exact dimensions on any particular team are difficult to anticipate. We can predict, however, that the greater the degree of homogeneity within any team, the smaller the impact of such factors. For example, a team composed of male, Mexican American working class members would not be expected to display significant conflict regarding gender, ethnicity, or social class, while the existence of diversity in any one of these areas might be safely used as a predictor of at least some difficulties in collaboration.

While the factors discussed in this chapter are important, they are not as important as the existence of distinct subcultures in a setting of medical dominance. Because they produce conflicts which are played out on the stage already set by subcultural differences and medical

dominance, they must be seen as contributing to, but not causing, team malfunction. Instead, they tend to exaggerate or skew the sense of difference in the dominant direction because the differences discussed in this chapter provided those in the medical or majority "in-group" with a means of expressing personal animus toward the social science "out-group." The very existence of in-group dominance over an out-group provided the structural basis for expressive behavior. This is a clear example of the manner in which standard ways of processing people, i.e. as clinician insiders or researcher outsiders, combined with personality, gender, ethnicity and social class to worsen an already difficult situation for the outsiders. As outsiders in a setting of medical dominance, the social scientists found that their gender, ethnicity and class contributed to the already-low status they held as program social scientists.

Notes

1. Erving Goffman utilizes the term "presentation of self" in analyzing social life (1959).

2. Adrian Furnham, David Pendleton and Charles Manicom, in their discussion of interprofessional relations, state that when members of a group perceive "negative acts" by out-group members they attribute this to personality. When the act is positive, it is perceived as an "exception" to the rule (1981:297).

3. Interpersonal relationships within a team may have some bearing upon the work of the group. Both John Horwitz (1969) and Joseph Eaton (1951) emphasize the importance of personal and professional security for the individual members of a team. An example of the operation of this

phenomenon within the CHP team was provided in Chapter V. When the social scientists perceived their lack of acceptance by members of the medical subculture, their resulting low morale inhibited their contribution as team members.

4. This pattern of physician workaholism in American medical settings has been reported by Maureen Searle. She notes the deleterious effect of this "obsessive-compulsive behavior" upon both the physician's emotional and physical health and the quality of patient care (1981:185).

   In spite of, or perhaps as a relief from, his extraordinarily busy schedule, Dr. X opened a shop in a nearby mountain state to sell imported Mexican handicrafts. This occurred during the anthropologist's second research year with the CHP team. The year afterward he ran for and narrowly lost a seat on the South City municipal council.

5. The sociologist and anthropologist also experienced role overlap. As the sociologist explained:

> Ours is not a problem of role conflict but of over-congruence or role overlap which has us underfoot of one another. This is a function of the fact that we both have essentially the same job to do.

6. Cartoons which staff members placed over their desks reflected their perception of a somewhat hostile and aggressive work environment. The social worker's cartoon depicted a drowning man-overboard whose shipmates were throwing him an anchor instead of a life-preserver. A "Doonesbury" cartoon by Gary Trudeau was in prominent display above the anthropologist's desk. It satirized an obsessive pre-med student who rejected all of Western civilization and culture in his single-minded pursuit of medicine.

7. The chief nurse practitioner was aware that "people think I'm arrogant." In explaining this perception, he stated:

> I'm cold. I realize I'm cold. I had a broken family when I was a child. I had a lot of things I realize make me this way. I can't go back to when I was a child and change everything from the beginning just because somebody wants me to be nice.

With regard to the team, he continued: "Some people are too friendly. The world isn't like that. It's a competitive place and we all have to fight for what we get."

8. Social science team members were aware of the physician's attitude toward conflict. One of the social scientists, for example, noted: "Dr. X thinks a high level of anxiety is good for people." None of the social scientists agreed with Dr. X's attitude, but when the sociologist once protested in a team meeting, the following exchange ensued:

> "I think we all enjoy conflict." - Dr. X
> "I don't." - the sociologist
> "I think you're lying if you say you don't." - Dr. X
> "Now wait a min . . ." - the sociologist
> "I'd be lying if I said I didn't." - Dr. X

To further explain himself, the physician continued:

> When I'm mad, I've got to tell somebody about it. I believe that people who want to avoid conflict are crazy. That just causes trouble. I think one good thing about this group of people is that they talk. They let each other know what they don't like.

When asked about instances in which conflict might be destructive, Dr. X replied: "If it's destructive, then you can learn to work with the person again and that's constructive."

9. In holding values which emphasized competition, conflict and aggression, the physician may have also been responding to the strong strain of individualism in American society. By doing so, he was handling the team as a coach might handle a sports team. However, he made no attempt to discourage the "hot shot" player concerned only with the points he might score for himself.

One problem seemed to lie in Dr. X's unwillingness to confront the individual with whom he was upset. Upon being told of conflict among team members regarding the completion of a certain team project, for example, he stated flatly: "Perhaps it's just my personality, but I don't want to get into this battle." Staff members were aware of this. One medical team member complained: "You can't ever get Dr. X to tell anybody to do anything."

Another administrative problem for the CHP was the physician's refusal to delegate authority. As one of the

social scientists pointed out: "Dr. X delegates only tasks, not authority." Similarly, a member of the medical team complained, in sympathy for a fellow team member: "She's a supervisor without authority, just like practically everyone else in this program."

10. Since the medical world is a male-dominated field (Campbell 1973), it is not surprising that the factor of gender might interfere with smooth team operation. A number of researchers have discussed the influence of gender upon the general process and results of research investigations (Daniels 1967; Wax 1979).

11. The physician demonstrated some sympathy to this inquiry, however, by then calling the anthropologist at home about program business and by treating her in the same manner as he did male staff members (for example, slapping her on the knee in a team meeting in the same gesture of encouragement he extended to male team members).

12. As Mexican Americans, their attitudes toward women may have reflected their cultural background. Judith Lisansky discusses the importance of social differentiation by sex in Hispanic culture in the United States, arguing that such differentiation is based on the related concepts of male superiority and female inferiority and of the male's status as linked to the "'purity' of his females" (1981:205).

13. He continued:

> We in the Mexican American culture--and maybe this isn't all of us but most of us--feel that the female should play a certain game and that the male should play a certain game and you're not playing that game.

The nurse practitioners did not approve of the anthropologist's non-traditional behavior. An example was provided in their response to her use of her maiden name. When she began work as a team member, one of the nurse practitioners insisted on calling her by her husband's last name. When she demonstrated a willingness to respond to either name, he commented on her continued use of her maiden name as her legal name: "No Mexican husband would allow you to do that."

14. The most aggressive and crude of this type of remark came from the chief nurse practitioner on an occasion when the anthropologist was discussing program roles with him. He

responded to her questions about his role with suggestive menace: "Do you want me to show you exactly what I'm good for?"

15. The term Anglo is being used here to refer to those team members not of Hispanic, in this case Mexican, background. Mexican American refers to team members of Mexican descent who were American citizens.

16. Auxiliary personnel attached to the team (for example, the EKG technicians and the summer students who did clerical or research work) were predominantly Mexican American.

17. It should be noted that the fourth nurse practitioner, a female stationed in an outlying clinic, did not define herself as Chicano. She was still in training and, possibly as a consequence of this, did not yet feel fully comfortable as a team member. She was a quiet participant in program activities, only rarely offering opinions. The secretary-coordinator of the team defined herself as Mexican American, did not feel she had encountered discrimination in her life, and believed the Chicano team members were being too hard on the Anglos. The Chicano social worker, although identified with other Chicano team members, was not inclined to making "radical" public statements about his ethnicity. The examples employed in this discussion of ethnicity, therefore, come from the Chicano public relations consultant and the three male Chicano nurse practitioners. Team members will be referred to by their chosen terms of reference as either Mexican American or Chicano.

18. Marilyn Montenegro (1976) investigated the difference between high school students self-identified as Chicano and those who called themselves Mexican American. She concluded that, of the two groups, the Chicano students were more conscious of their ethnicity and of discrimination and more anti-Anglo in their views.

19. The CHP hired as a consultant a Mexican American physician trained in Mexico and the United States and currently living in the United States. In terms of these ethnic definitions, Chicano team members did not consider this physician to be Mexican American or Chicano, but Latin American. The term Latin American is commonly used for Mexican Americans in Texas.

20. Definition of the Chicano movement as a "brotherhood" denies the existence of a Chicana sisterhood by ignoring it.

21. In her review of the social science literature on interpersonal relations among Hispanics in the United States, Judith Lisansky (1981) reports that Mexican Americans and Chicanos tend to have a generally negative and distrustful perception of Anglos. The one exception is provided by acculturated or middle class Mexican Americans, whose attitudes are more positive.

22. This feeling of discomfort which the Chicanos felt when in "Anglo society" was also evident in the social worker's request soon after beginning work with the team that the anthropologist cover for him in dealing with the family of an Anglo patient. He explained: "I don't feel comfortable counseling Anglos."

23. Expressions of this type are used in this discussion as examples of reactive racism because they are responses to the traditional racism of Anglos toward Mexican Americans.

24. Another expression of racism can be found in the nurse practitioner's joke in which Anglos were referred to as "bolillos," a type of hard-crusted yeast roll eaten in Mexico as bread: "Anglos are like bolillos--they are hard on the outside and soft on the inside and they get stale very quickly!" Shirley Achor (1978) reports common use of the term bolillo instead of Anglo by Mexican Americans in Dallas.

25. This statement is also sexist. In traditional American culture, females have been the prized possessions of males, and white females have been desired above females of other ethnic backgrounds. By making the statement that he would not sleep with a "white" female, the Chicano team member was rejecting a fundamental value of traditional American culture. Male Anglo team members saw this ethnic position, above all others, as being "ridiculous" to the point of being somewhat demented.

26. Shirley Achor mentions this movement of disillusioned "accomodationists" into political commitment as Chicanos (1978:126). For information on Chicano political organization in recent years see Rodolfo Acuna (1981), especially Chapters 8-12.

27. In reviewing the literature on Mexican Americans, Achor notes its "implicitly pejorative undertones" (1978:166) and the critical response by Mexican American social scientists.

28. Chicano radicalism was stimulated by the "Black is Beautiful" movement and Chicanos were equally active wherever there was a substantial Mexican American population.

29. Or, in the words of another Chicano nurse practitioner:

> You guys are just a couple of Anglos who are going to start telling us stuff we already know. A couple more Anglos trying to tell us about our own culture. Maybe ask us what it's like instead of trying to tell us what it's like.

Mexican American team members did not have the same attitude. As the secretary-coordinator noted:

> I think it's good to have Anglos study Mexican American culture because you yourself could take things for granted that other people from outside your own nationality could pick up. The first anthropologist knew so much about the Mexican culture. I was really so astonished. He would tell me things I had never heard before. It was fascinating.

30. This particular nurse practitioner explained the ethnic situation within the team to a program outsider: "Just being an Anglo is a disadvantage. The second anthropologist doesn't speak Spanish. Dr. X has been with the program all these years and he still doesn't speak Spanish." The nurse practitioners did not approve of an Anglo having been hired as program anthropologist: "I don't believe there's not another Mexican American anthropologist out there."

31. Another social scientist's anger with regard to this situation can be seen in his purposeful mispronunciation of Chicano as "Chicken-o." This social scientist organized a chess match with the chief nurse practitioner, made a poster billing the event as a kind of duel between "the Anglo and the Chicano," and posted the notice in the nurse practitioners' office. Although he was certain he could win the match "hands down," the series of two games was tied. The Mexican American secretary-coordinator disapproved of linking this match to racial issues: "If

the chief nurse practitioner loses, it makes all the other Mexican Americans look like jotos (fools) of the month."

The radicalism of the Chicano team members led them to reject all Anglo involvement. In so doing, they alienated Anglo social science team members who otherwise would have been sympathetic to their position. The social scientists then suggested that Chicano interest in Mexican American affairs served only to allow them to improve their own financial standing by "climbing on the backs of their brothers." This idea was bolstered by a lack of evidence that the Chicanos were politically active, by seemingly unsophisticated political underpinnings for their radical statements and by their materialistic views of success. It was this latter characteristic that led one of the Anglo social scientists to openly criticize Chicano team members:

> I'm getting tired of hearing this "these are my people" stuff. How do you think Mexican Americans picking in the fields would react if you drove up to the barricades in your silver sports car? They'd know in a second you're not "one of theirs."

The Chicano, of course, argued that migrant workers' identification with him and his car would be complete and that he was actually advancing the Mexican American cause by driving a late model sports car.

32. This nurse practitioner described himself and the other nurse practitioners:

> We don't come from very well-to-do people. My father was a migrant worker. We were exposed to the barrio situation and to the tasks that Mexican American people go through.

33. It is not surprising that the structure of medical dominance might be supported in part by the underlying structure of social class. Within medical settings, for example, the usual pattern is for physicians who have consistently come from the upper or professional classes (Geiger 1974) to expect to make decisions which nurses, usually from the working class, will follow. In the interdisciplinary/interprofessional team setting, this structure was complicated by the addition of social scientists who, as members of the upper or middle classes,

expected to have a decision-making role equal to that of the physician.

34. It was the first anthropologist who noted, with regard to his own reception by the team, that "academia is the kiss of death around here."

CHAPTER VIII
CONCLUSION

The purpose of this dissertation was to evaluate the collaborative difficulties encountered in a modern interdisciplinary/interprofessional health care team, the CHP team of South City. Problems of conflict have plagued such teams from their inception, despite optimistic expectations that interdisciplinary/interprofessional teams would yield more effective health care than traditional forms of medical organization. Nearly every article and book dealing with the phenomenon of teamwork mentions collaborative difficulties, thereby documenting their widespread presence. Despite the attention accorded team conflict, however, there is no study which satisfactorily explains it. Instead, analysts have tended to ignore the work of researchers in other disciplines and have failed to offer a satisfactory analysis of the process of teamwork. An integrated explanation of team collaboration is therefore lacking. This study of one particular interdisciplinary/interprofessional team is an effort to fill that gap by considering socio-cultural setting.

In attempting to develop a methodology which facilitated a more comprehensive investigation I turned to the field

of applied anthropology. After reviewing the literature I adopted a qualitative approach which entailed use of the ethnographic case study method and focused on the existence of subcultures within the larger cultural setting. A qualitative case study approach permitted a more broad-ranging and exploratory investigation than previous studies and made it possible to more thoroughly explain team dysfunction.

Results

This study argued that the CHP team was divided into two subcultures which formed as a consequence of professionalization and subsequent professional practice. One subculture consisted of medically oriented members of the professions and provided clinical therapy in the form of psychological or medical services. The other subculture was made up of social scientists who acted as researchers rather than clinicians.

While advertising itself as an egalitarian union of medical and social science personnel, the CHP team actually operated as separate but unequal groupings. Within that structure the medical group wielded considerably more influence over the team than did the social scientists. More specifically, the physician dominated the CHP team. The mirror image of clinical dominance within the team was the secondary or subsidiary status of the social science researchers. Despite their being invited into the program by

Dr. X, the social science subculture found its potential contribution being minimized by the medical subculture. The nurse practitioners held the most consistantly negative views toward the role of the social scientists.

The social scientists were dismayed to discover that, as a result of their subsidiary status within the team, they were expected to play what they perceived as no more than a supporting role. Indeed, they found that the clinical bias of the program led medical team members to feel free to tell the social scientists what to do and how to behave as team members.

Team conflict within the CHP manifested itself in the form of role conflict between subcultures, with those members of the medical subculture playing a dominant role. At the root of this conflict were differences in goals and values between the clinical and research subcultures. For example, the goals upon which the clinical team focused were the provision of direct medical and social care to patients and the ensurance of continued program funding. These goals were easily quantified and thus medical team members could "point" to what they did. The social science goals of research and teaching, however, were diffuse and difficult to "see," particularly because both researchers used qualitative methods. Differences in goals also reflected certain

distinctions in subcultural values. Team members conceptualized these differences by classifying the social scientists as "thinkers," as opposed to medical "doers." Clearly a very simplistic notion, members of the two subcultures nevertheless tended to separate themselves along these lines.

Two forms of role conflict surfaced within the CHP team and, in both cases, problems arose when social science researchers were requested to assume roles they believed to fall more properly within the domain of the clinical team. In the first case, medical personnel asked the social scientists to participate in program funding and social care activities. In the second, the clinical team seemed to deemphasize the importance of research and to seek instead public relations efforts. The social scientists responded angrily to these requests, interpreting them as evidence of medical disrespect for their role as researchers.

Personality, gender, ethnicity and social class also had an influence on the team as elements dependent upon the character of individual team members. Although given secondary importance as factors affecting team collaboration, each was examined as contributing to team dissension within the context of medical dominance. Clearly, such factors will vary significantly from team to team. The personality

of the physician had the most powerful impact within the team, because of his powerful position as team leader.

The fact that many of the team members were Mexican American males of working class background also affected team operations. In a complex relationship involving Mexican American ethnic resentment of Anglos, working class antagonism toward upper class values and male emphasis on hard work and competition, the team tended to generate tensions between Mexican American and Anglo, male and female, working class and upper class. The social scientists, as middle class Anglos and, in the anthropologist's case, as a female, found that ethnicity, gender and class background tended to lower their already-low status as social scientists on the team.

Even though the sample employed in this study is small, the observations I have made fit well with reports in teamwork literature. Both Saad Nagi (1975) and Peter New (1968), for example, confirm the difficulty of defining professional domain which members of the CHP team experienced. In doing so, they touch also upon the impact of organizationally structured strains such as medical or clinical dominance. That administrative forms of organization are important to the nonconflictual operation of a team is also supported by other researchers (Rodman and Kolodny 1971; Golin and Ducanis 1981).

In addition, my examination of factors operant within teams is supported by David Banta and Renee Fox (1972) who report on differences in values and goals between professional groups, as does June Huntington (1981). Both of these works deal not only with what appear to be subcultural differences between professional groups, but also discuss the negative views which one professional group may hold with regard to another. Adrian Furnham, David Pendleton, and Charles Manicom (1981) hold that the mere separation of individuals into interoccupational groups triggers intergroup prejudice of a kind similar to that experienced within the CHP team. Finally, both Noel Chrisman and Thomas Maretzki (1982) and Arthur Kleinman (1982) report on the need for anthropologists working in medical settings to adapt to medical values and goals as part of establishing their research or consultative role.

Discussion

The predominant theme of this work has been the clash between professional subcultures in a health care delivery setting. Within the CHP team staff members offering an evaluative contribution came into conflict with personnel intent upon producing clinical services. The resulting skirmishes were fought in a setting ordered by clinical dominance, as medical clinicians formed the majority subculture in opposition to the social science or minority

subculture. Socio-cultural factors in the form of professional subcultures were most important in influencing general team operations and in determining specific roles to be played within the team.

It is possible, then, to discern the operation of the health care delivery system on the basis of its collision with a particular subculture not previously included in health care. Clinical personnel carried out their work as they had been trained to do in professional schools and as they were directed to do in clinical settings. The clinical order of work activity and interpersonal interaction was thus a familiar part of their working lives as hospital employees. When faced with the seemingly odd behavior and attitudes of "newcomer" social scientists in a medical setting from which the social scientists had previously been excluded, clinical team members began to articulate statements concerning how a team member "should" act. By attempting to "instruct" the social scientists on proper behavior, the clinicians were in effect defining their own ideas and behavior.

That clinical personnel did not attempt to change their own attitudes and behaviors to match or even to accomodate those of the social scientists is an indicator of the strength of clinical dominance. Although social scientists were invited to join the CHP team, clinical personnel seemed

to expect them to do so on medical terms. This assumption was not communicated clearly to the social scientists. As a result, the researchers mistakenly believed they had been hired to produce innovative contributions in a field suffering from medically defined problems of inefficiency and ineffectiveness.

Although the social scientists eventually learned they had made a mistake in assuming they were entering a friendly environment, it took them several months to do so. This process was lengthened by the confusion caused when medical personnel proudly mentioned the presence of the social scientists to program outsiders and when the clinical staff told the social scientists they could do "whatever" work they wanted. These facts contradicted the gradually dawning perception of the social scientists that they were not an important part of daily team operations and that they had a very low status within the program. Once they began to realize more fully the difficulty of their situation, the social scientists refused to adapt on anything other than their own terms.[1] This attitude was reinforced by the fact that some team members were very disagreeable when in the presence of the social scientists. The evidence in Chapter VII bears witness to the hostility sometimes generated. The particular history of this team may have produced an unusually high level of role conflict which, in turn,

possibly encouraged the social scientists to refuse to bend.

In general, the social scientists within the CHP team were unwilling to participate in the same activities as the medical team members. Finding there was no defined research role within which they might operate, they did not effectively define a new role for themselves. Instead, they continued to insist that they be allowed to specialize as researchers. In retrospect, it seems that they may have been naive in their resistance. They sincerely believed, however, that in assuming medical-like roles they would lose their special contribution and thus their effectiveness. This attitude prevented them from participating fully in team life and eventually led to their being replaced by new social scientists.

The result of role conflict within the team was that when the medical and social science subcultures achieved a deadlock in which each side waited for the other to adapt, members of the minority social science subculture were ejected by the dominant clinical subculture. Some clinicians, for example, reported "celebrating" upon learning that the first anthropologist had decided of his own accord to leave the team for another position. When the initial nine month contract for the sociologist and anthropologist ran out in the summer of 1975, only the anthropologist was

asked to continue as a part-time consultant to the program. A few months later, Dr. X asked the sociologist never to return to the program premises because he believed the sociologist was "sneaking around" the program and "causing trouble." Although no longer employed by the program, the sociologist had been spending some time around the program "wrapping things up."[2]

When the anthropologist submitted a proposal in the summer of 1976 that she return to the program as a full-time team member, her idea was rejected by a majority of the team. Dr. X supported the idea, but when he put it "to the vote" with other staff members, only he and the technician-administrator voted for it. The third program anthropologist, the four nurse practitioners and the secretary-coordinator voted against the proposal, stating that the anthropologist hadn't "done anything" or that it wasn't "worth it."

The anthropologist's being "voted out" of her evaluator/research role provides final evidence for the argument that the team had not evolved a proper framework for working with behavioral science. Afterward, the physician worried that the team had become an organization which "couldn't accept people who had new ideas, who presented them forcefully and who tried to introduce change."[3]

It is not surprising that differences in role expectations might occur when academically oriented professionals are placed in clinical settings. In such cases, researchers expect to tell clinicians "what" they are doing and "how" to do it more effectively and efficiently. Most members of the medical subculture on the CHP team, however, did not seek this kind of input from the social scientists. They already knew "what" they were doing and they did not define themselves as having problems requiring the services of a social science investigator.

Instead, medical personnel seemed to want the social scientists to help them "do" what they were already doing. In other words, they appeared to want the social scientists to work "for them" in carrying out previously set program goals by already established means. To achieve this end, medical personnel wanted generalists, persons who could act both as trouble-shooters in predicting and preventing future problems and as consultants in smoothing over unexpected problems which the program encountered. This conflicted with the social scientists' expectations. Believing that their specialized research role was the reason for their being in the program, they did not want to assume a generalized role.

At the most basic level, role conflict for the social scientists resulted from their perception of the medical

subculture's denial of social science competence, or specialization, as evaluators. Who, then, did they believe the program accept as a social scientist? "A yes-man," suggested one of the social scientists. By this he meant not a social scientist with an overly compliant personality, but someone who was willing to play a very generalized role. Someone, that is, who did not wish to specialize as an evaluator/critic. The third program anthropologist to be hired to work with the team appeared to be this kind of person. Stating that he "did not like doing what anthropologists do," meaning traditional research, he believed that "anthropology is whatever anthropologists do."[4] This anthropologist did not perceive his role as that of a critic. As he once stated: "Doctors think social science isn't as important and I agree with them." He was, as the original social scientist had predicted, "well-liked" by all medical team members even though he was occasionally criticized for being "too easy."[5]

The evaluative presence of social scientists appears to have been a source of anxiety and strain to medical team members. The anthropologist was a third party to the team, listening with a third ear, looking with a third eye and talking about it. It was difficult for team members to accept the role the anthropologist played as their constant companion, a living self-corrective mechanism.

The voting out of the anthropologist may have also provided the team with an opportunity to show Dr. X who was in control of whom. When the time came for the team to vote, management (the physician and the technician-administrator) voted for the anthropologist while the workers (the four nurse practitioners, the secretary-coordinator and the third anthropologist) voted against her.[6] Team members were well aware that the physician strongly supported a continuing role as evaluator for the second anthropologist and that in voting against this idea they were voting against his idea. In this context, it is possible the anthropologist became a symbol in their struggle for power, a symbolic political football.

The history of the CHP team can be viewed as a case of developmental change, a study of the physician's attempt to reorganize and thus to change the operations of a service program. As creator and head of the team, it was he who initiated the change process. His attempt to add social scientist/evaluators was unsuccessful. As a result, Dr. X discovered that although it was his chosen mission to build social science into a medical team, he was unable to graft it onto a team that didn't want it.[7] Part of the physician's difficulty was that he did not have the necessary understanding for achieving such a change. Dr. X's approach was that one achieves teamwork by adding "important people."

With such an approach, the problem of justifying the presence of team members with an indirect relationship to service remained unaddressed.[8]

The difficulties of collaboration need not be repeated in this or any other similar team. By adopting certain structural cures for the problem of coexistence between researchers and clinicians, such problems can be minimized. The most obvious cure is to place the researchers in a tightly organized and closely administered position in which their only mission is to produce evaluation of team activities. Another possibility, and one which would probably free them more completely from the biasing influence of close association with the team,[9] would be to place them in an evaluative unit outside the team, perhaps located in the hospital.

Such considerations, however, bypass the issue of whether teams are the most appropriate means of affecting collaboration. Such an assumption is actually unwarranted, as the superiority of teamwork has not been conclusively demonstrated. There is a need for evaluation of the very concept of teamwork.

Given the popularity and widespread use of teams, however, it is safe to assume they will continue to be a common part of health and human service delivery. Researchers may also continue to find they must operate in clinical settings

without the benefit of strong administrative support and without a clearly defined role to fill. If there is to be future interplay between the fields of medicine and social science, it appears that the social scientists must adapt by accepting the structural realities of the setting. In doing so, they do not need necessarily to abandon their hope for a meaningful role in health care delivery. They must seek a means of adapting to medical expectations while at the same time making certain they are able to achieve their own goals. Researchers in a setting similar to that of the CHP, for example, might participate in program public relations and funding projects while concurrently carrying out evaluative research. In this manner, the social scientists would be creating a comfortable role for themselves within the confines of the program.

Such a compromise should not be too difficult to affect, particularly since some medical personnel are open to the field of social science and welcome its participation. Dr. X, for example, was very curious and interested in the possible contribution of social science to the field of medicine.[10] Moreover, many or most medical personnel may not be certain of the benefits which might accrue from social science consultation. Although generally aware of their own working setting, clinicians may actually need to be shown what is lacking and what steps can be taken to

remedy it. In such settings anthropologists may need to be more entrepreneurial in advocating greater participation.

Beyond the question of acceptance for social science researchers, there is also the issue of how members of practicing teams might best handle the existence of subcultures and of professional dominance. The most helpful approach would be to recognize the existence of professional subcultures and to observe the power relationship between them. This was, in large part, the purpose of this study. Given a comprehensive understanding of the dynamics of the work setting, the solution is to work either to change the perceptions of other team members or to adapt to them, or both. Detailed knowledge of the professional alignments allows one to predict behavior when certain work-related issues are raised and to develop solutions.

Notes

1. Such purist attitudes toward research are not uncommon and this is the reason practically no social scientists can do service or mission-oriented research.

2. The sociologist and the physician were involved in a disagreement concerning the control of data the sociologist collected while working for the team. The physician had also heard from several sources that the sociologist was "badmouthing" the program.

3. When asked by the anthropologist whether any of her personal characteristics had a bearing on team members' rejection of her services, the physician responded strongly in the negative:

> No. Try to objectify it and don't take it personally. You're asking me for constructive

> criticism. Well, it just wasn't your fault. It isn't personal and you shouldn't take it that way.

Groups commonly reject newcomers who do not conform. Theodore Mills, for example, reports on replicated research indicating that group members first actively try to convert deviating members to group norms. If this fails, they reject the deviant (1967)

4. This statement, of course, is a tautological definition of anthropology. If anthropologists do minor surgery, is this what anthropology is?

5. The economist provides a similar example. Although he suffered many of the same problems and shared the frustrations of the anthropologist and sociologist, he did not attempt to perform an evaluative function within the team and was also "well-liked." He was described by a member of the medical team as someone who "wouldn't rock the boat."

6. Solomon Asch, in his experiments with "a minority of one versus a unanimous majority" (1952:457), observed interaction between individuals and groups when the issue was one of remaining independent or submitting to social pressure and discovered a "pronounced movement toward the majority" (1952:457). This phenomena may have been in operation within the CHP team.

7. A social scientist attempted an explanation of the team's reaction:

> The idea is the rejection syndrome. They needed to have social science grafted onto the CHP for various reasons but they also had a reaction to it. They had a rash. They didn't like it. They knew they had to take it without knowing entirely why; but social science was a foreign body and many things in their "body" fight this, resist it and try to kill it.

This process had also been observed in the field of organizational development. See, for example, Phillip Mirves and David Berg's edited collection, Failures in Organizational Development and Change (1977).

8. In the usual medical setting, doctors actually have an indirect relationship to clinical care. Dr. X, for ex-

ample, managed the health care team rather than directly managing the patient. This situation is reflected in a nurse practitioner's assertion that the nurse practitioner's relationship to the patient was "closer and even more important" than that of Dr. X. Even so, the physician played a pivotal and very necessary role insofar as he was legally responsible for the health care services provided by other team medical professionals.

9. G. Gordon and E.V. Morse, in reviewing evaluation reports in sociology journals, note that evaluators not affiliated with a change program or its funding agency were significantly less likely than affiliated evaluators to find positive results, at a ratio of 1:7 (1975).

10. The physician believed:

> One of the roles of the social scientist is to evaluate team functioning and team approaches and try to change things, maybe by trying different methods.

APPENDIX A
SEMI-STRUCTURED INTERVIEW SCHEDULE
(given to all team members)

1. How would you define social science?

2. What kind of a relationship should there be between social science and medicine?

3. Is social science a help to medicine or does it prove to be more of a hindrance to medicine?

4. What should the contribution (to medicine) of a _____ be?

   anthropologist
   sociologist
   psychiatric social worker
   systems analyst--economist

5. Should any other disciplines be involved? What about a project coordinator?

6. Is it appropriate for a social scientist to work in a medical setting as a _____?

   therapist
   teacher
   researcher/evaluator
   administrator

   Are there any other possible roles?

7. Have social science and medical personnel within the CHP team been able to work together successfully? Why or why not? What is the source of any particular problems?

8. Do you think the gender of team members has any bearing on their acceptance or ability to work as a team member? What about ethnicity? Age? Personality?

APPENDIX B
PERCENTAGE OF WORK ACTIVITY FOR TEAM MEMBERS
(FISCAL YEAR 1974-1975)

	Anthropologist	Sociologist	Economist	Physician-Director	Nurse Pract. 1 (South City)	Nurse Pract. 2 (South City)	Nurse Pract. 3 (the Basin)	Nurse Pract. 4 (the Basin)	Social Worker	Public Relations Consultant	Secretary-Coordinator	Technician-Administrator	PROGRAM TOTAL
Patient Medical Care	-	-	-	54	15	50	53	60	-	-	-	4	20
Patient Social Care	15	10	-	5	15	10	18	18	35	-	1	8	11
Funding	-	1	25	5	15	-	2	-	30	65	20	2	14
Other Public Relations	5	5	5	-	10	-	5	1	5	15	10	1	5
Research	35	25	25	5	3	10	-	-	2	5	-	1	9
Self Education	5	5	10	15	5	5	5	10	3	-	-	10	6
Teaching	30	33	-	6	15	10	2	-	2	-	-	5	8
Management & Administration	-	5	25	3	10	3	-	-	10	2	6	50	10
Travel to Outpatient Clinics	2	1	5	7	12	12	10	10	13	13	3	5	8
Secretarial	8	15	5	-	-	-	5	1	-	-	60	14	9

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Linda Catherine Illingworth was born in Lafayette, Indiana, on October 14, 1950. In June of 1968 she graduated from Clay High School in South Bend, Indiana. She received her Bachelor of Arts degree from Florida Atlantic University in 1972 and her master's from the University of Florida in 1977. In the past ten years she has worked as a clinician, administrator and/or researcher in the areas of teamwork, family and sexual violence, child and family therapy and suicide and crisis intervention. She is presently married to Lorne McWatters and holds a position as psychotherapist at the Center for Children's Services in Danville, Illinois.

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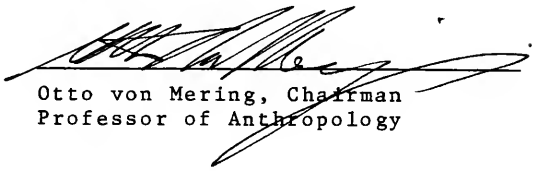

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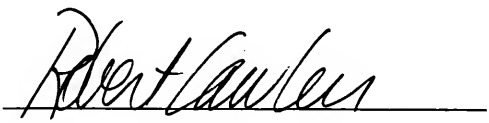

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